MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
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10:09 a.m.*

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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AGENDA PAGE

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P R O C E E D I N G S

MR. HACKBARTH: I'd like to thank our guests for coming. As always, we will have public comment periods. We will have one at the end of the morning session and another at the end of the day.

Our first topic for today is quality improvement for health plans and providers, a November report. It's November. So Karen and Mary, whenever you're ready.

DR. MAZANEC: Good morning. This presentation will continue our discussion of quality improvement standards in the Medicare program that we began at the October meeting. I will begin by briefly summarizing our analysis and findings and then Karen will discuss the draft recommendations.

Since MedPAC's report is due to the Congress by the end of November, we are asking the commissioners to comment on the content of the draft report and to discuss and finalize the recommendations.

As you recall, in the BBRA, the Congress directed MedPAC to study and report on how Medicare should apply quality improvement standards to both the fee-for-service and the M+C programs. At the October meeting we presented

our analytical approach and findings.

To briefly summarize, our analysis consisted of three parts. First, we identified the goals of quality improvement standards and then examined the manner in which they are applied by private accreditors, regulators and purchasers. Next, we analyzed the M+C standards and the QI efforts in the fee-for-service program. And finally, we evaluated the feasibility of applying standards comparable to the M+C standards to each type of plan and provider.

To comply with quality improvement standards, a plan or provider must be able to measure care, improve care by influencing provider behavior, and then remeasure and report on the results of their efforts to improve care.

Based on our analysis we concluded that first oversight in private and public purchasers efforts are duplicative. Private accreditors may have similar but not identical quality improvement requirements as the federal government. Compliance with multiple sets of standards may increase costs without adding additional value in terms of quality of care.

Second, we found that providers and plans have varying capacities to comply with quality improvement

standards. Often the structure of a plan or provider will determine whether it can comply with quality improvement requirements. Tightly integrated HMOs are better able to measure care and influence provider behavior, and thus are probably in the best position to comply with quality improvement standards.

Conversely, PPOs with large, loose networks of providers are less able to meet QI requirements due to problems with obtaining medical record data and influencing provider behavior. While providers, especially clinicians, are in the best position to influence the quality of care, holding providers accountable for their performance on clinical outcome measures is made more difficult because few individual providers treat large enough numbers of patients with a specific clinical conditions. Finally, we found that rewarding or assisting providers or plans may further stimulate quality improvement.

QI standards represent only one way to address quality problems. In our analysis, we noted that public and private sector purchasers are exploring many other ways to stimulate quality improvement efforts. But at present, little information is available on the most effective

mechanisms of improving care.

Karen will discuss her draft recommendations.

MS. MILGATE: I wanted to note, first before we went through the recommendations, that they look slightly different than the version that you may have gotten in the background materials. We changed them some to make them more concise. So they aren't exactly that way, but they are the same as the slides that you had received.

We had four proposed recommendations. Two of them addressed ways that CMS could apply quality improvement standards in the future. The second two address other ways that CMS and Congress could further stimulate quality improvement in the addition to the application of standards.

The first draft recommendation is that the Secretary should work to reduce duplicative oversight efforts when applying quality improvement standards. There are several strategies CMS could use to reduce duplication. The first is that before actually developing quality improvement standards CMS should evaluate the extent to which private sector standards already in use will actually achieve the goals that it has for its population. This will lessen the duplication that's built into the design of the

standards.

Further, when determining how to apply standards, another way to reduce duplication is through the ability to use private accreditation in the deeming relationship. This is well developed in the fee-for-service part of Medicare, however it needs to be established in Medicare+Choice. It's important to note that CMS is looking towards doing this. They are currently evaluating several accreditor standards to determine whether they're rigorous enough to establish a deemed relationship with those accreditors for Medicare+Choice.

One aspect of applying quality improvement standards that's not addressed by deeming is the duplication in the number of measures that plans or providers are required to report on. In the Medicare+Choice program, it's really unclear whether it's necessary for Medicare+Choice plans to actually be reporting on the HEDIS measures as well as additional Medicare specific measures that are defined in the QAPI program.

In fee-for-service, the issue is more of a future issue. Many private sector purchasers, as well as CMS, are considering requiring a core measure set to be reported from

various providers. So there's a need to standardize those measures so that hospitals and other providers are not necessarily reporting on so many different measures for different oversight bodies.

If there is an attempt to standardize those measures and they aren't able to standardize them, as in meaning using the same measures, CMS should consider whether they should just use those measures in the private sector.

Once the need for additional standards has been determined, the Secretary should take into account the capabilities of providers and plans when developing and applying quality improvement standards. That is recommendation number two. It really comes out of the analysis of the different levels of capacity that providers and plans have to perform quality improvement.

Examples of how this could be done include, in the Medicare+Choice program, to recognize the limits on record abstraction, CMS could allow less integrated plans to only collect data on measures that rely on claims data. In addition, to address the limitations of some plans to be able to measure and improve care, they could either encourage further plans to use PROs more proactively or else

possibly even require plans to use the PROs that are out there to assist them to do their measurement improvement efforts.

Another way that this option could play out, to address issues about equity between plan requirements, is possibly to give all plans the option to only collect data on claims data. There's been a significant blurring between types of plans and Dr. Ginsburg talked this morning further about the fact that more plans are going to broader networks. So that might be an option for all plans in the Medicare+Choice program.

In fee-for-service, because the ability to measure and improve care varies widely, particularly by size of the provider, any standards that CMS applies shouldn't be too specific and should give providers discretion in how they actually meet those standards. And to address data validity issues that Mary highlighted in terms of the sample sizes for particular clinical measures, they could just use clinical measures for quality improvement internally however develop more broad measures to look at providers for accountability purposes, such as did the provider put in place specific safe practices? They could use patient

perception measures, those types of measures which would rely on a larger volume of patients rather than just those in specific clinical areas.

The implications of this recommendation are several and I wanted to talk just a little bit about that. This recommendation is designed to obtain the greatest amount of quality improvement for the lowest cost by recognizing the different capacities in plans and providers. It may also address the different levels of quality risks associated with different payment and care management incentives. However, depending upon how strategies are implemented, it may also require some plans and providers to be held to more rigorous standards than others.

The next two recommendations are other ways that CMS could work to stimulate quality improvement that are not standards. Because of the limited knowledge of the effectiveness of quality improvement standards and the limited ability for some plans and providers to meet them, it is also important for CMS to explore these other options.

The first option that we have here is draft recommendation three, that the Secretary should explore ways to reward providers and plans that work to improve quality.

There are several different ways this could be done. Actually, Dr. Ginsburg talked about a couple of them this morning. One is simply by paying higher payments to those who improve quality or those who may simply decide to agree to measure their quality. This could also be done in the form of incentives for consumers to choose particular providers or plans.

The second one would be public acknowledgement of those who put in this extra effort or consistently perform higher. Once again, this could be information to consumers to help them determine what providers or plans they may want to choose.

The other way that this could be done, that we saw some evidence in both public and private sector, was to place a lower level of regulation on those who perform consistently well or who put in the extra effort.

The last recommendation is for Congress to instruct and fund CMS to expand quality measurement and improvement efforts. It's very general in how it's written here. What we had hoped to achieve by this recommendation is to recognize the limits of some providers and plans in meeting some of these quality improvement standards and to

support and affirm the government role to assist plans and providers in actually measuring and improving care. So to suggest that the PRO program is a solid strategy for what CMS hopes to achieve and perhaps expand that program.

In addition, in many of the conversations we had with private sector folks and clinicians and all types of providers, it was pointed out to us that the weak link in understanding here is really in how to effectively engage clinicians in improvement efforts, and that there needs to be more research on how that actually should be done, and that that would be another form of assistance to providers and plans, simply to do the research necessary to learn about what are the effective practices and to diffuse the information out into the plan and provider world.

One place to begin here would be to do an in-depth analysis of the efforts and the payoff from the Medicare+Choice quality improvement efforts and the fee-for-service program. Actually in the next six months we're going to start having some pretty good data on the results for the last three years in both programs on how effective their efforts have been.

So those are the draft recommendations. We are,

of course, here for any questions or comments you might have and look for some final recommendations.

MR. HACKBARTH: Thank you, Karen. Ralph?

MR. MULLER: One of the questions as we look at quality improvement efforts going forth is to what extent we're looking for these improvements to occur at the provider level, versus the kind of health system level. I think both in your presentation and written material it's very clear that trying to hold providers accountable for care that goes on outside their setting -- since most providers do not have a monopoly of the responsibility for the health care of a person. During acute episodes they might. So it's very difficult, in a sense, to hold them accountable for the whole health status of a person or a population.

On the other hand, some people are looking at measuring health status of populations across time. So I think one thing, it's my conjecture and I won't ask you to comment on it, whether at least for the foreseeable future it's more likely to be able to measure quality of care at a provider level rather than the kind of systemic way that goes beyond providers. And therefore, whether our

recommendations should be specific about that, that providers is where we can measure right now even though in the long term we may be wanting to look at more than that.

And coming out of that therefore, on recommendation three, which I think is important but I think we need to stress even more, is right now I think there's a suspicion among some that those who are able to measure are as likely to be penalized as rewarded. Sometimes you're almost better off being a black box that can't be scrutinized rather than one that is open to scrutiny.

So I think some sense that if, as you say, the Secretary should explore ways to reward providers, I think it's important if we want to keep encouraging them to measure the quality which, as you know, is a difficult effort given your many pages to that fact, that we have to be very clear in saying there have to be rewards for this as opposed to penalties for trying to measure quality.

The third point I would make along those lines, and this was triggered more by some of the comments that were made in the discussion this morning. If one thinks about some of the safety net providers and some of the capacity problems that we're seeing in some of the settings,

is it a sign of good quality or poor quality that safety net providers are stacking up in terms of capacity problems?

In one way, if you just kind of look at crude measures, you would see the fact that people are waiting for care and may not be getting the care on a timely basis is a measure of poor quality. On the other hand, it may be an indication that those institutions, those doctors, those neighborhood health centers and so forth are available to take care of a population that may not get it elsewhere.

Again, your discussion points out how difficult it is at times to take any of these measures at face value without understanding them more fully.

So just to summarize, especially on recommendation three, I would urge us to point out that if we want qualitative improvements to go forth, we have to be very clear that people don't get penalized for being part of the measurement process. Obviously, if there's evidence of poor quality there has to be some action taken towards that. But we don't want to have, in that sense, people penalized for being in the forefront of trying to measure quality.

Certainly we see, whether it's by looking at the HMOs versus other kinds of plans or looking at large

institutions versus less developed institutions. Right now we're looking for quality improvements to really be in areas that are more developed, as opposed to institutions that are less developed.

DR. NEWHOUSE: I found this a particularly difficult set of questions to deal with. Let me start by saying I think there's a lot of data showing that there's ample room for improved quality. So the notion that the country shouldn't, in some sense, be addressing quality improvement is not an issue.

In terms of the report, although you do distinguish them, I think since I'm going to make some negative remarks about quality improvement and wind up trying to recast recommendations three and four, I would start out by even more sharply I think than you do, distinguishing quality improvement from quality assurance. And say quality assurance has to be a given as the minimal level of quality. So that it's clear that we're talking about quality improvement efforts, as opposed to quality assurance efforts.

On quality improvement efforts, where I'm going to come out is putting together recommendations three and four

into research and experimentation with various kinds of incentives, by which I mean both payment and information since public reporting is a form of incentive.

My concern with just going whole hog into this, in addition to what Ralph said, with which I agree, are at least three. One is many of the measures that I'm familiar with, certainly the outcome measures and many of the process measures, require risk adjustment. That's an imperfect art at best. It also will require auditing the risk adjusters, which is an issue. I think in implementing it would set up concerns about coding of the kinds we've seen on the reimbursement side.

Secondly, I think there's a concern about teaching to the test, in effect. Our measures are better in some areas than others, for example in cardiovascular than in cancer. If I were running an institution and I were faced with a bunch of measures of quality of my cardiac surgery, I would put more resources into cardiac surgery and fewer into the unmeasured areas.

Which implies, by the way, if we're going to do research on this, we're going to have to find out what's going on in the unmeasured areas, which is a real challenge.

The third kind of problem is really a selection problem. Any of the measures that require patient compliance is going to set up selection against non-compliers. For example, the immunization measures. We also know that sample size is certainly a problem at the provider level. There's some very good analytical work on that at the physician level.

So what I would do, as I say, would be to take recommendation three, that the Secretary should explore ways to reward providers and work to improve quality, which is consistent with the notion of research and experimentation. And I would recast four, I think, in that light. I noticed the original draft we got did have research mentioned in four and it's taken out of the slide here.

And by the way I would mention, if we're going to talk about a specific agency, which we do in four, and we're going to talk about research, we should talk about AHRQ as well as CMS. I don't know that we need to talk about a specific agency, we don't in recommendation three.

I guess I'm very skeptical of how much good we can actually do relative to how much harm we can actually do if we adopted relatively potent incentives for quality

improvement, again as opposed to quality assurance.

MS. MILGATE: Can I just ask a question back to you, Joe, so that I make sure I understand what you said?

Your point is that you don't think that we know enough to do draft recommendation three by itself, and so the thought is that we need to do more research to understand how we should steer folks?

DR. NEWHOUSE: No, it's really recommendation four that's my bigger problem, where you say should instruct and fund CMS to expand quality measurement and improvement efforts. Whereas three, you say should explore ways to reward providers and plans that work to improve quality.

Well, explore ways has a research experimentation feel about it, whereas four sounds like much more turn on the juice. So there's a bit of tension between those two recommendations as they're worded. I would come down on the side of three.

MS. MILGATE: Would softening four help that though?

DR. NEWHOUSE: I don't know that you need it.

MR. HACKBARTH: You're saying just drop four?

DR. NEWHOUSE: I think so, or meld three and four

together in more of a tentative mode.

MS. MILGATE: So include some of the ideas in the discussion that may be under four under three, which are about assistance and research?

DR. NEWHOUSE: Yes.

MS. BURKE: Glenn, can I just follow up with a question related to this? One of my concerns in looking at the old draft of recommendation four -- but I'm very much in sync with where Joe is. It's also fundamentally the question as to whether CMS is the right place to do all of this, particularly when we get later in our discussion about issues of regulatory burden and things of that nature.

The question is what role should CMS play? And what are we presuming the answer to that being, specifically in this context? Joe raises the question of whether or not AHRQ or somebody else ought not to be involved in this to a certain extent. But I think as we look at these going forward, I'm also concerned about the question as to who and where the capability ought to lie, and who is best funded to do either the research. In demonstrations it might well be CMS because of the population, but I think that is a question that we need to understand. And I don't want to

assume that CMS is the right answer in all these cases, because I'm not at all certain it is. I think there are real questions about their capacity over time and how many things we ask them to do.

MS. ROSENBLATT: I was going to suggest that recommendation three be expanded to say that work to improve quality and measurement. So just consider incentives for having better measurement, particularly on the health plan side.

The other comment I was going to make is Wellpoint got a lot of press recently in our efforts to reward providers for quality. It might be worthwhile to have some real live examples of where that's being done in the marketplace.

The other thing is just linking up, as Ralph did, the comments we heard this morning from Paul, he used words like consumer driven, information driven. This becomes so important.

DR. ROWE: Two points. One is I think that we should have some reference here with respect to respondent burden, as Sheila mentioned. We talk about it in regulatory burden and tomorrow we'll talk about Medicare+Choice topics

that you have under tab J. It talks about the plans in terms of what risk adjustment data we wanted to put in, the plans want X and MedPAC wants Y, et cetera. It was clear that the collection of those data was dropped because CMS was trying to find some way to lessen or make the M+C program a little more comfortable for the plans.

So we should at least be mindful of that as we talk about this. Otherwise it will seem disconnected from these other chapters.

That having been said, I think that there's another piece of this which is even more important and which urges Medicare to do this. I think unfortunately, in the health care marketplace with respect to health plans, there has not yet been the development of a significant number of purchasers; i.e., employers, who are willing to pay for quality. They talk about quality but they purchased based on price or other kinds of benefits. But there has not been a very significant movement in the marketplace to pay for quality.

It doesn't mean there aren't some sponsors, and we have some and I'm sure Wellpoint has some and others, who will pay for what they perceive to be quality. But given

the fact, particularly with the tight economy, we were talking about defined contribution earlier and other things, that really Medicare is in the position to develop the experiences to see what kinds of quality oriented products, if you will, from health plans in the M+C program might be effective for the members and providers and everybody else.

It really seems to me that in the absence of anyone else stepping up that there is a very significant opportunity for Medicare here to lead the way.

And so from that point of view, I think it might be helpful in the beginning to talk about Medicare's role in the entire health system. We sometimes focus just on Medicare and not talk about the rest of the system. And if we have something about the disappointing lack of free market initiatives in this area, that that would support Joe's idea about some specific demonstrations and things like that. Thank you.

MS. NEWPORT: I have some editorial comments that I'll share with you ladies later, but I guess the emphasis here focuses on -- a little bit of tone, too -- is that there were some formative efforts by health plans to market and start marketing on quality initiatives. That's one of

the reasons that NCQA, as well know, NCQA and other accrediting organizations are starting to be utilized more and more to measure quality.

So the early blunter instruments to measure, as Alice would say, have been refined over time and have been used, some of which BBA piggybacked on.

I think that the concern or the subtlety that's lost in this is that we seem to have, because to some extent health plans are integrated systems, the ability to measure more concretely what is being done. And then the struggle is then how do we bridge to the fee-for-service area?

One of the things I don't think we even approach very well is that what impact has plan measurement on provider groups and provider systems had to raise the bar on quality because we are in the marketplace? And I think it would be helpful to recognize it, even though they may not be measuring all of a physician's practice or all of a hospital's care that there are some standards there that intuitively impact on how they perform. Because I don't think they have an on/off switch. I hope not, anyway.

So I think we need to kind of look at this iteratively, that the focus and the emphasis and the

delegation of resources needs to then go to a broader level, albeit incorporating tools and techniques that might be more right-sized for that particular fee-for-service area. So I think I'd like to see something more affirmative around that.

Then I think we cannot underestimate the cost in terms of the regulatory burden, that may be justified and cost effective, because it does improve quality, with overbuilt systems or overwrought systems in some cases.

So one of the concerns I would have with maybe the last two recommendations is that we make sure that in the statement that -- we're seeking balance and we're seeking exportation of things that we've learned in one area to areas where, because of the breadth of them, that we haven't had the opportunity yet to devise techniques to have meaningful measurement and quality indicators.

So I think that's it. Thank you.

DR. NELSON: I had a different interpretation of recommendation three from that that I think Joe presented, because he was looking at this in terms of supporting research and experimentation. I looked at this as the Secretary finding ways to reward tools that clearly reduce

errors, such as computerized order entry in facilities that 100 beds that would like to do it but they don't have the resources. The skilled nursing facilities that are having greater incidents of bedsores simply because they don't have the resources to put in place the processes that reduce that.

So I would hate to see draft recommendation three diluted. We have to acknowledge the fact that there are restrictions in the ability of facilities to fully take advantage of the science that we know supports the use of certain modalities. And what the Secretary should explore is ways to assist those who are able and willing to incorporate those quality assurance techniques with Medicare paying its fair share of the bill.

So I don't have any argument with having Joe's point expressed, but I would hate to see what I believe you were driving at lost in that process.

DR. STOWERS: Not to digress back to recommendation number one, but to me there's a great discussion about what's happening in the private sector and in the public sector. I'm just wondering, the way we read this as it stands alone, that when we talk about duplicative

oversight efforts that that can get interpreted to just be doubled efforts within Medicare or whatever. And that this recommendation on its own really comes across to say that we ought to be looking at the efforts between the private and public sector. And sometimes these recommendations kind of stand on their own and I don't think that point comes across in the recommendation.

I think the discussion is great.

MS. MILGATE: So you want it to be more duplicative efforts generally because it's not just public versus private?

DR. STOWERS: I think we need to somehow come across in the recommendation come across with the fact that it's the duplicative efforts between what the providers are having to do on the private side and what they're having to do on the CMS side or the public side. That doesn't come across to me in the recommendation, that it could be just doubled efforts within Medicare.

I think somehow we've got to get that point across because I could see someone reading that and saying well, this is one more regulatory or simplification of CMS that we're asking for and not really the broader picture that

your text backs up.

MS. RAPHAEL: I guess as I look at this I put in order of importance that, to me if the purchaser doesn't recognize and reward quality, it isn't going to happen. So to me that is the most important recommendation that we can make with the caveat that as you measure quality you don't look very good when you uncover a lot of things that were hidden before. And you don't want to end up being punished because your statistics don't always put you initially in the best light. But somehow the effort of measuring and investing should be recognized and rewarded.

Secondly, for draft recommendation number one, I don't think the issue is activities. I think the issue is that there is a lack of integrated focus between all the people who are surveying and measuring you. They don't all have the same standards, so it isn't just that they engage in different efforts at different times, but it's that they have often completely different standards that you're being judged by. So I think that recommendation number one needs to somehow talk about the fact that there needs to be more coordination of the standards that you're being judged by.

And thirdly, I think that we need to somehow

foster more experimentation, whether you call it research, exploration. This is very hard work and we don't know very much. We don't know how valuable this all is, what this will all amount to. So I think we are in an experimentation phase, and I think that's healthy. I don't think we can lock in at this point and say that we know enough about what works in the clinical care process are, what works in the kind of customer satisfaction and response and access area.

So I just think that somehow one of these ought to capture trying to promote more experimentation and dissemination of results in this field.

DR. BRAUN: I just wanted to mention, in draft number two, I think while we have to take into account the capabilities of the providers and the plans, we also I think need to be aiming for equal protection of the beneficiaries across the Medicare program. Certain plans are being asked to do certain things and others are not being asked to do them. So I think we need to find ways that the protection can be equal for all beneficiaries across the program.

The other thing that I want to mention was I think when we're talking about deeming, it's important to be sure that if this is private accreditors doing the -- obviously,

private accreditors -- doing the accrediting, it needs to be a transparent process when it's a public program. I think that's part of being a public program.

MR. FEEZOR: I just I guess wanted to underscore comments Jack and Alan made about Medicare really being able to be in a position of leadership in putting money up, particularly in the rural and underserved and heavily concentrated areas of Medicare enrollees.

Parenthetically, Karen I probably need to, if you're unaware of the effort in California where we're trying to get about five or six major payers together to, in fact, pay for performance under the Integrated Health Association. I don't know whether you've seen the recent work that they're doing on that.

Two other quick comments. I guess I was struck by Ralph's observation that if we believe that, in fact, and certain the retreat of Medicare Choice would suggest in at least the short term that there's greater individual choice is going to be more the marketplace going forward, then that does put the emphasis on our quality measures perhaps going down more at the provider level as opposed to system or PPO level. And yet I'm struck by the paradox that puts us in

and the fact that if about 90 percent of Medicare's expenditures and about two-thirds of the enrollees have more than one disease state that they're dealing with at the same time, the difficulty of getting true measures, if you're talking about accountability. So I just sort of put that as a paradox that I think we'll have to be dealing with going forward.

DR. REISCHAUER: One small suggestion. It may not be possible. But in the discussion about duplication, I wondered if there were any data that would say what fraction of nursing homes go through two or three of these procedures or hospitals? Because that might give it a flavor. It might not be available, but it would provide a number here or there.

I have sort of a general observation to make and that is looking at quality it strikes me that there is cost reducing or cost neutral quality improvement. That is if you do the right thing health care costs will go down or they won't rise and the outcome will improve. And a capitated plan should have an incentive to adopt those types of quality improvement measures, although many of them I don't think do, as Alan suggests.

Individual providers who care more about volume don't have a financial incentive. I mean, they have in a sense a moral imperative to do that. So that's one kind of quality improvement. But probably a lot of quality improvement is really cost increasing. It improves health but it costs more.

And it's difficult, under a system like this, to expect providers or plans or whatever to respond. There are some of these instances in which the value of the health benefits exceeds the cost of the quality improvement and some where it probably doesn't. But in either case we have to ask who's going to pay for this? It won't happen on its own.

This really gets to Carol point. Is CMS going to pay for it or are we going to expect the patients to pay for it?

I have, going through these recommendations, problems with rewarding people for improvement as opposed to high level. You know, if the assurance standards are pretty minimal, which they are, I don't want to have a system which rewards somebody for going from a minimal level to minimal plus and doesn't give anything to somebody who is really

superior who slips a little in a year but still is way above the other.

You can think of a temporary program to help certain particular entities like rural hospitals develop the capacity to operate effectively at a higher quality standard, but those would be temporary. The reward system and incentives system really should be on high level, as opposed to change.

DR. NEWHOUSE: A couple thoughts on the discussion. One is along the lines of Bob's point about costs. I don't think we know a lot about costs of many of the -- take computerized physician order entry that Alan talked about. We do know something about that reduces errors. I don't think we know much about how much it cost to train the physician staff to use it, how much it costs to maintain it over time.

Maybe it's sufficiently costly that you can't afford to do it at every hospital. I don't know. But I think that's something that would need to be looked at before we had a requirement to put it in everywhere.

The second point goes to Bea's point about equality. I think that's almost inherently impossible. One

of the places we know where there's a problem is handoffs from one provider to another. This goes back to the point Ralph made earlier. That's almost got to be there in the traditional plan and in private fee-for-service as well, because it's kind of nobody's business.

In the health plan world one could conceptually hold the plan accountable for handoffs. But if one does then that's, by definition, asymmetric from the point of view of the beneficiary, which gets you into an issue of how do you handle the symmetry.

DR. ROWE: Reaction to Bob's comment. I think it's very good and I think we should pay attention to it here. I think it would be helpful to have a section early on in this chapter, which is really excellent, that talks about the relationship between quality and cost. Because we don't go into that and there is a lot of basic stuff there but we just sort of dive into improving quality. Make it explicit.

You might consider using the traditional analysis of Chassen, that there are three kinds of quality problems. There's overuse, underuse, and misuse. And if you get rid of overuse yes, that does save money. But if you get rid of

underuse, which is particularly a problem in gender-related areas like heart disease in women getting less treatment, or in racial and ethnic disparities in treatments, that costs more. It's good, you get more quality but we should understand what we're in for.

And correcting misuse, there's a cost associated with the identification of misuse and correcting it. It could cost more, it could cost less. But some sort of structure like that I think would be helpful because it helps to align the incentives or disincentives associated with the various changes in these different models, such as a capitated model, et cetera. I think that that might be helpful.

And you might reference the IOM report, which is not referenced here.

MS. MILGATE: It will be.

DR. ROWE: And talk a little bit about their approach.

MR. DEBUSK: I just have one comment to make on automated order entry and these sort of things. That's inexpensive, simple. That bear has been crossed in the medical profession for a long time. We deal with that

constantly. And that's lacking.

You talk about this quality thing and you think of how are you really going to improve quality? And if quality systems are implemented, costs should go down. I agree with you very much on that. But in the field of medicine, the protocols, the clinical pathways, these things are what we really need to be working on to better describe these, put them in the system, and then process control, production control, break them up into parts and evaluating them on that basis, and then look at your outcomes, your production.

We're way back on the whole process of what quality is all about. It's good to talk about it but probably we should visit industry a little bit and see what they're doing about some of these things because we're in the production business in patient care today. It's just so archaic how we do some of these things and we talk about these things.

Can you buy quality? Can we do what we're trying to do? I don't believe we can.

MS. ROSENBLATT: I just want to address the point Joe made about consistency across fee-for-service versus HMO or health plan because at Wellpoint we have actually been

trying to figure out how can we measure quality for our PPO members. Our technical people and our physicians got together and came up with a very simple way of measuring something like compliance with mammograms and pap smears.

The idea was if a woman sees five doctors and she gets her annual mammogram then all five doctors are said to be that's okay. Because maybe one asked her -- if she went to her general practitioner and she had had the pap smear with her gynecologist and the general practitioner said have you had your pap smear and the answer is yes. Well, then obviously the general practitioner did not have to do it.

So I do think there are simple ways of doing that, and that we need to just take a new approach to thinking about how we do those things so that we can measure it in the fee-for-service world. And I think again, just coming back to the comments made this morning, consumers I think are ready for this type of information.

And Medicare is the 800-pound gorilla and I am strongly in favor of Medicare trying to do all types of things, even in a fee-for-service world.

MR. HACKBARTH: In listening to the conversation I hear broad agreement on at least two basic points. One,

that this is important and it would be valuable for Medicare to be a leader, so far as possible. And two, that this is a developing field and there are a host of very complex issues having to do with measurement and risk selection and so on.

The conclusion that I personally draw from those two points, which I agree with, is that we ought to be looking at encouraging voluntary efforts in quality improvement. We don't know enough to be mandating this or that be done. I think that should apply across all sectors.

That's the approach, as I understand it, now being taken in traditional fee-for-service Medicare. We try to encourage quality improvement measurements using the PRO structure. I think that is also the approach we ought to be taking with regard to private health plans and M+C so that we do not impose a burden, an unequal burden, on one of the competitors in the M+C system that we've established, particularly when we know so little about this developing field.

So I'd like the tenor of the report to be great, important stuff. Let's do it, let's encourage it, let's finance, research, et cetera. But let's be wary of what we don't know and let's not tip the balance in the M+C

competition by mandating something for some competitors but not for others.

DR. NEWHOUSE: Aren't those two linked? In other words, if you're going to encourage it, however you're going to do that, you want to learn something from having done whatever happens out there. So since it is a developing field, I think you want to link your two points.

MR. HACKBARTH: Say a little bit more, Joe.

DR. NEWHOUSE: This goes to your point about we want to encourage voluntary improvement. Well, we want to encourage voluntary improvement but we want to learn something about the efforts that various factors undertake to improve quality. Maybe we want to induce them to undertake those efforts by doing some formal kinds of experimentation and paying them for that, to see what happens.

But however it's done, if it's just exhortatory or if it's more than that, we certainly want to learn something about the effects of this, with the hope that we can then generalize from that, whatever it is that's going on out there.

MR. HACKBARTH: Could I just clarify one point? I

have some concerns about the wording of draft recommendation two, which at least as I read it says that you might require some organizations to do something because they have broader capabilities or enhanced capabilities that you don't require other competing organizations to do. And I think that actually is counterproductive.

I think that that tension, given how little we know about this field, we could be handicapping organizations that are trying to do the right thing. And that's just not what we want to do at this point. So I don't want to say well let's put burdens on people in accordance with their capabilities. Let's try to encourage everybody, fee-for-service, various type of private plans, while we are still experimenting and learning about this complicated field.

DR. NELSON: I'd like to take your synthesis just one step further though, in terms of the Medicare program being more than just an interested bystander in this. I'm probably mischaracterizing where you're going, but nonetheless, I wouldn't want someone to interpret our position as being passive about it.

That's the reason why I like the idea of the

Secretary exploring ways, maybe through demonstration projects or some other way, to see if incentives can be built in that actually promote quality improvement. I can live if it's not among our recommendations. But I wouldn't want us to come out with a report that was interpreted as being passive when there is an opportunity for the Medicare program, along with business and others, to actively promote, through the use of incentives, quality improvement.

MR. HACKBARTH: Just for the record, I don't want people to interpret what I'm saying as being lukewarm about this. I do think it's important and I would like to see Medicare be a leader. But I wouldn't like to see us respect what we don't know about how to do this.

DR. ROWE: I think I was going to make the same point Alan did. I thought I heard, in your comments and in Joe's, a general interest in avoiding disadvantaging some elements, and at the same time exhortation to cheer on people who wanted to work in quality. And I think we've been doing that a long time with no effect. We really need to put some incentives in to see if that will make a difference. So I would cheer them on with an incentive in these specific demonstrations.

And I think we should put that specifically in the report, that on a demonstration basis is not going to significantly disadvantage other elements that don't have the capacity to respond to the challenge. It might stimulate them to develop the capacity.

DR. REISCHAUER: Just judging from CMS' behavior over the last few months, it's clearly desperately looking for ways to pump money into managed care organizations. And an aggressive demonstration initiative, tied to quality, I think is the most defensible way to do that. And it also serves the purpose of allowing us to learn something, both about what's possible and where the limits might be.

I was going to mention something else about different standards for different types, but I won't.

MR. MULLER: This is consistent with the last few comments, but in light of what we'll be discussing the rest of the day in the session where we will be talking about cost concerns and updates and physician payments and so forth, having the quality agenda, the cost agenda, and then obviously -- as was referenced in the comments this morning -- given some of the cost pressures that are going on in premium increases, more and more people are likely to get

uninsured in the near future.

We have to be looking at to really encourage the kind of quality improvements everybody seems to be talking about, there have to be the kind of incentives that a number of people just mentioned.

I would also point out, just listening to the comments over the last hour, I would say the ways in which people approach the quality discussion is probably as varied as any discussion that we're likely to have. And people really come to it in so many different ways, which tells me that nobody is even close to a consensus as to how to really improve quality. I think that's consistent with Joe's comments earlier.

So therefore, a strong sense of experimentation, a strong sense of reward for that kind of experimentation, but also I think a sense of caution that this agenda is not moving forward anywhere near as quickly as other agendas because it's so complicated and likely to stay complicated for a long period of time. So I don't see a likelihood of any major breakthroughs on this.

This is as apple pie as it gets, you're supposed to be in favor of quality in health care. But just to

reference one of Bob's questions earlier, who's against in a sense rewarding people who are doing very well? But look at just one of the common HEDIS measures. Are we better off as a community if you get immunization rates in some tough areas up from 15 to 50 or better in some homogeneous area getting it from 75 to 90? One can debate that considerably.

But some of the real problems in this country, something as simple as that, are getting the rates from 15 to 50 in certain of our populations and so forth. In some ways, not to belittle the difficulties of some more affluent homogeneous areas, tweaking it from 75 to 85.

So again, heavy on experimentation, heavy on the incentives, but also understanding this is going to compete with some other agenda that we're going to be talking about in the next 24 hours.

MS. BURKE: Just one cautionary note. I don't disagree at all with the direction you're going and I think we ought to acknowledge that there are things that we don't know and we ought not be requiring things of plans or individual providers that we are uncertain of. And I think all of the efforts at demonstration make a great deal of sense.

Having said that, I would be very concerned if the message that came out of this that we were any less committed to an expectation of requirements over time, that in any way we suggest that over the long term that this is going to continue to be some kind of a voluntary system, that there will be no explicit expectations on the part of the major purchaser of what it is that we expect providers and plans to do.

And I wouldn't want us to suggest that we're backing away from the requirements already in statute, or that we don't anticipate that once we have the information in hand and the capacity to encourage or incentivize providers to do certain kinds of things that we won't use those to put in place some fairly clear expectations as to what plans and providers ought to do.

So while I agree we ought not put in place things we don't know how to do, I don't want to suggest that over time, once having established those things, that we are any less committed to expectation that plans and providers will, in fact, comply with some kind of standard.

MR. HACKBARTH: The existing law in fact requires

-- has differing requirements. You said you don't want to see any backing away from the existing differing requirements?

MS. BURKE: I don't want us to appear to be stepping back from A, the current statutory requirements, acknowledging that there are differences, that there were exemptions of non-HMO plans in terms of what was required of M+C plans. My point is simply I don't want us to suggest that we are backing away from an expectation of a system that will expect certain kinds of behaviors on the part of plans and individual providers that we don't yet know today what we need to know in order to know what those expectations ought to be, or how best to measure.

So I acknowledge that we don't have enough information today to put in place a whole series of new requirements. But I don't want to suggest that we are unwilling to do so once we have the information in hand, or that we are any less committed to quality being critical in terms of our purchasing decisions going forward.

MR. HACKBARTH: The last part of that I feel entirely comfortable with. It's the first part, the unequal requirements that exist in current law, which makes me

uneasy.

MS. BURKE: Right. So are you suggesting repeal of the statute to deal with that?

MR. HACKBARTH: I'm certainly suggesting a change in the statute so that we would say that we ought to have equal requirements across the sectors. There might be varying requirements at some point in the future once we know more about what the right thing to require is. I don't think that the current law has struck the proper balance.

MS. BURKE: So as part of this recommendation are we suggesting a repeal of the statute or a modification of the statute? Is that what your expectation is?

MR. HACKBARTH: Maybe what we need to do to really nail this down is actually go through the recommendation language that we would be talking about. Why don't we put up the first --

MS. BURKE: Because I didn't see that in any text that I read.

MS. MILGATE: Can I just say a couple things that may help us come to some middle ground here on this? The difference in statutory requirements between HMOs and non-HMOs, in terms of how it's played out in the regulatory

realm is primarily just one thing. And that is that the non-HMOs don't have to demonstrate improvement on this extra QAPI project. That's for reasons that we talked about.

I wanted to just point out the distinction between the standards which require plans and providers to put processes in place to do QI and then the other whole set of measures. That's actually where there's much more controversy, as you have all talked about, the uncertainty about what you're measuring, how well you're measuring it, whether what you come out with actually makes any difference.

So one way to approach the equity issue would be perhaps to suggest there should be equity in establishing processes to try to improve, but then pay around with how much extra is required in terms of measurement. Because that's where the real lack of knowledge is and where it becomes much more difficult to actually compare plans with other plans, providers with other providers, because they're so different and have such differing levels of ability to actually measure and report on what they've done.

DR. ROWE: I don't know whether or not the people who drafted the statute had this mind, but it seems to me

that the way the elements of the health system have evolved that are involved in providing or organizing or paying for this care, that different elements have very different structures and functions and inherently different capabilities. And I think there is a difference between equity and equitability here, that we may not be able to get equity and be fair because we would be disadvantaging some elements that just are not organized in such a way as to provide the information or have the control over the providers, or whatever. The difference between a tight HMO and a PPO, for instance, is the reason why NCQA can accredit a tight HMO reasonably well but it's much harder with a PPO because the plan has much less control over the providers.

So I think in our search for an improvement in the effort to gain and enhance quality, I don't want us to disadvantage anybody. So what I hear, and this is new to me, is that the reduction to practice of the statute really only gives us one distinction which does not seem, to me at least, to be an unreasonable distinction.

So where I come out is that we probably don't need to modify the statute. What we need to do is emphasize that the way it should be applied should be such a way that

mindful in the differences in the elements of a health system, they should all be accountable for quality and none of them should be passed over with respect to this. I think that's the message.

DR. NEWHOUSE: I think we all agree that the inherent capabilities are not the same. So my point is that to the degree we go on from that to say we would require different things, and to the degree those things have cost implications then reimbursement also has to be unequal.

MR. HACKBARTH: What you don't want to do is create a system where people say boy, I don't want to develop any capabilities because then they'll have expectations of me. Disavow any responsibility for anything and keep my capabilities at a minimum because then they leave me alone.

MR. MULLER: That was the discussion we had earlier about if we improve quality in the system why not reward people for doing so. And given the kind of concurrence through the last through moment's discussion, that there are different capabilities inside the system and likely to be for a very long time, if not forever, inside the system, one wants to encourage those institutions -- by

and large institutions -- who have capabilities to use those capabilities in advancing quality.

As opposed to something as perverse as either saying we'll penalize you for it or we'll demand that you have costs added to your system but we won't pay you for that because we can recognize you, we can deem you, we can accredit you, we can give you conditions of participation and therefore we'll hit you with all those things. But by the way, there's no reward on the reimbursement side. That's truly perverse.

I think it's very difficult to use the kind of equity equitable argument that Jack and Bea have raised to assume that all parts of the system, whether it's providers, plans and so forth can somehow act equally. That's just not a reality.

MR. HACKBARTH: That's right.

MR. MULLER: On the other hand,

one wants to encourage us in a powerful way and it does get to costs and change in behavior that we're trying to encourage.

So I think in terms of the recommendations, I would state the varying capacity recommendation in a

positive way by saying where these varying capacities exist -- and some of them have already been acknowledged by having the HMOs versus the non-HMOs have the BBA requirements -- we should encourage and reward and learn from those kinds of things, as opposed to going backwards on them -- which I think is Sheila's point in part. But definitely it would be truly perverse to have institutions that are capable of improving quality and be penalized for doing so, either in terms of increased regulatory requirements, scrutiny, costs, disadvantage and so forth. That would be a very perverse outcome.

MS. RAPHAEL: But I think the flip side of that is not to let anyone off the hook. Because I don't think we should be saying that there are some providers or systems that don't have the capability and therefore somehow they don't have to adhere or try to reach certain standards.

MR. MULLER: If I can just, Carol, I think one of the assumptions in all this, I think, is that sooner or later the quality -- like it does in other sectors of the world -- will be recognized and rewarded. Now it may be so far off it won't happen in our lifetime.

But I think one of the reasons, and not just in

terms of professional ethos and concern that people try to improve their quality, is in fact there will be a reward for it in the longer term to being a better provider of services. So to that extent, there should be self-regarding behavior that causes institutions, providers, doctors, et cetera, to try to improve their quality.

DR. ROWE: I think we can handle this pretty easy because I think we're at kind of risk for a crisis of agreement here, that we should recognize that different elements have different structures and constitutive abilities that does inherently differentiate their capacity to do certain things. A fish just can't develop lungs and walk out on land. It doesn't have the genome for doing that. We can't punish it for not doing that. That's just the way it is.

On the other hand, what we should do is say that given the differences and the capacities of the different elements, each of the elements should do whatever it can, given its capacities and its structure, to improve the quality of care. And that different elements will use different pathways to get there.

I mean, I think we want to distinguish a

constituative genomic aspect of this from the fact that we don't want to go where Glenn was suggesting we don't want to go, which is people will not develop capacities because then they will have expectations placed on them. We want them to develop those capacities within the framework of their entities.

I guess a paragraph about that might then be helpful.

MR. HACKBARTH: I think the only way we can bring this to a conclusion is to actually talk about language of recommendations. So what I'd like to do is go back through those one by one.

DR. NELSON: Glenn, I think it would be helpful if draft recommendation two was rewritten and brought back to us in the context of this discussion, because this discussion changes the tone quite a bit and puts more emphasis on the -- acknowledges the differing capabilities but puts more emphasis on an ultimate goal of everyone being accountable for improving their performance.

MR. HACKBARTH: I agree that it needs to be rewritten. The process will be, we need to provide enough direction to Mary and Karen that they know what to bring

back, or think they know what to bring back. That's what I want to make sure of. And then tomorrow or sometime later today we will actually review a redraft. But let's quickly go through.

Draft recommendation one, I think I heard agreement. We won't vote right now.

MS. MILGATE: I heard two changes. Would you like me to cite them?

MR. HACKBARTH: Actually I'd like to not spend additional time right now. Recommendation two, the key points that I think have come up is that we don't want to unfairly burden organizations in the competition, but we want to encourage the development of capabilities which may vary according to the type of organization it is. So it's encourage as opposed to uniform mandates.

DR. ROWE: This sounds like a little too much of a cop out here. What we want to do is add something to this recommendation that says mindful of the differences, we want to require each element to enhance quality to whatever degree it has the capability of doing so. Something like that.

MR. MULLER: Mindful of, we should encourage and

reward.

DR. NEWHOUSE: I think there has to be something about reimbursement.

MR. HACKBARTH: To me that's the rub. If in fact there are different costs attendant to these different approaches, then you start to unfairly handicap one party versus the other in the M+C competition. And so I think you need to have more of a reward mentality than a mandate mentality.

DR. ROWE: Particularly given the current of the M+C competition.

MR. HACKBARTH: Which is critical context for this. This is not a program where we have private plans flocking into it.

DR. ROSS: As we're trying to stitch together these walking fish of Jack's, does that mean we bring together the discussion on recommendation two and pull in number three on that?

MS. BURKE: I guess my impression is two is not specific to creating [inaudible] three and four. I saw this as a different issue, which is the acknowledgement of the differences between the plans and looking at what the

expectations ought to be. I think what Murray's saying, at least what I hear you saying, is the issue of the incentivizing and the development of systems to look at different methods for encouraging behavioral changes is an issue, I understood, in three. I understood this to be a different question.

MR. HACKBARTH: So you see them separate?

MS. BURKE: I guess I understood their points to be somewhat different.

DR. ROSS: I guess the problem is I hear the different discussion on recommendation two is I'm hearing two thoughts that I don't think are mutually consistent. The thing that possibly squares the circle here is to bring in the reimbursement rates. That's what I was looking for.

MS. BURKE: Right.

MR. HACKBARTH: The Congress asked us, should they require the same thing of all the different sectors. And I think we have agreement that the answer is no, we shouldn't require the same of all these different sectors because you can't. And so then the next question is well, should we require variable things or should we have a reward mentality that if people invest in improving quality we will support -

- help them pay for it through reimbursement, whatever?

And I think that's where potentially we have disagreement. I'm saying I think that we ought to have the reward/support mentality and not let's require things of different people because of the competitive consequences.

DR. NEWHOUSE: Maybe the way out here is to talk about require in the context of quality assurance and reward in the context of quality improvement.

DR. ROWE: Or innovation. I think that that's -- because we don't want to say that if you don't want to go on the pathway of getting extra reward for improving quality, then you have no responsibilities with respect to delivering quality. We don't want to go there, right?

MR. HACKBARTH: There ought to be a quality assurance minimum required.

DR. ROWE: And that standard might change over time, right?

DR. REISCHAUER: But if you have the same quality assurance standard across all delivery systems, isn't that as far as you want to go?

DR. ROWE: It's not as far as I want to go, but I'm well known to be way out anyway.

DR. REISCHAUER: So you would have different assurance standards for different types of --

DR. ROWE: No, I would have assurance standard across the board for anybody who's involved in providing or paying for care for a Medicare beneficiary. And then I would have an added reward for innovation and enhancement to quality.

MS. BURKE: Can I make just one side note, going back to the old days of a staffer? It seems to me the first recommendation ought to deal with the question. If the question that we were asked is should we apply the same thing across the board, if our answer is no, that ought to be the first thing we say. That's the question. If we have the answer, we ought to agree that's the answer and we ought to say it.

And then we have all these other things. But are we agreed that the answer to the explicit question that was asked is no?

MS. MILGATE: But there was also a question of how.

MS. BURKE: I understand, but nowhere in these four recommendations do we answer the question.

DR. NEWHOUSE: I think it's no, but if you do it anyway then you should reimburse differential.

MS. BURKE: Right. But it seems to me the first thing we need to do is do we have an answer to the question as asked? And if we do, we ought to state it. And that ought to be the first thing we say. And then all the modifiers, if you do, how you do, what you do, and if you want to do something else.

But there was a question asked, do we have an answer? Are we agreed? It ought to be stated.

MR. HACKBARTH: Just to maintain some semblance of schedule, what I'd like to do is have Mary and Karen come back with some recrafted recommendations, and we'll help you do this. There may actually be two conflicting recommendations that capture what I think is a difference of opinion here, and then we'll do that tomorrow around 10:30 or so.

This has been a very helpful discussion for me, and thank you, Mary and Karen, for all the work on the paper. It was well done.

Now we're going to go on to an easy item, reducing Medicare complexity and regulatory burden. We're all warmed

up, David.

MR. GLASS: We want to get commissioners' reaction to the draft report, which should have been handed to you today. We have a new version. And see if we can get agreement on draft recommendations.

As Murray mentioned earlier, there are a couple of pieces of legislation under consideration on this subject, and you can see them up there. They have a couple of points on common, as shown below, but the approaches to doing those are not necessarily exactly the same. So the different styles we're talking about, they may or may not come to agreement in time. We don't know. And I don't think the Senate has done anything yet.

But the point is that Congress still is clearly concerned about the burden issue.

This is just to remind you a little bit of the context for some of the recommendations. CMS, providers, suppliers, beneficiaries, standing between them, in many cases, are the contractors who actually carry out the program. As you can see, there are a lot of them now. The carrier's fiscal intermediaries, regional home health intermediaries, durable medical equipment regional carriers,

program safeguard contractors, the PROs and QICs, which haven't happened yet. They're on the way. I can't even remember those.

I think we counted about 139 of these now and they're kind of Balkanized between -- they're split up by geography, by function, by setting of who they cover. So there's this large population of contractors out there. And they do important things. They do the claims payment, they do medical review, many audits, overpayment determinations, and it's all done by contractors.

The balance here is that I think there's about 4,000 or 4,200 people in CMS. There are about 38,000 full-time equivalents out in the contractor world. So the Medicare world, to most providers, suppliers and beneficiaries, the people to actually talk to are this large set of contractors.

The problem is they use different systems from each other and they interpret rules differently from each other, and it leads to what we think is a major burden on providers, suppliers and beneficiaries. And you remember, our goal was to search out sources of complexity in the program and simplify it. So we'd like to eliminate entire

layers of interpretation and burden in that way.

This isn't working profoundly well because, as you may remember, GAO showed that when people call up to ask for information, 15 percent of the time they get a correct and complete answer, which means 85 percent of the time they don't. So that is a major burden on providers, suppliers, and beneficiaries, to not be able to get correct answers about what is in the program, particularly if they're going to be prosecuted for it later.

Why is it this way? It's this way because it's the way the program began. We wanted to have local contractors. We were going to have local emphasis. We were going to pay local rates. It's not true anymore. We don't do that. So it may be time to get rid of some of these arbitrary distinctions and divisions and remove some layers of interpretation.

That takes us to our first recommendation, which is should move to a standard nationwide system of claims processing and eliminate local descriptions of policy and regulation. So we're saying we want to have CMS come out with a clearer statement of what is the policy, what is the regulation, and how it's going to be carried out through the

claims processing and not have many interpretations of that going forward to the providers and beneficiaries.

We also want Congress to allow CMS to contract as necessary to implement the standard system efficiently, which means CMS should be allowed to divide this between contractors and government personnel. They should be able to decide how many of each they want and how they divide up this claims payment world.

How to deal with local medical review policies is an issue that comes up if you go to this way of doing things. And the question is if you don't have local carriers around -- in many cases we don't have them around anymore anyway, by the way. But if you don't have them around at all, what about all these 8,000 local medical review policies that are out there?

It turns out that of those, most of them actually are for -- the reason they were instituted is because they were to explain why denials were being made automatically. That's the purpose of a local medical review policy in most cases. So if you want to a standard claims processing system, presumably you would not need those anymore.

By the way, this was done with the DMERCs, the

durable medical equipment regional carriers, now create a common set of LMRPs. So we have a national local medical review policy for DMERCs. So it has been done, apparently it's possible and everyone is happy with it, I'm sure. But it is the case where it's happened.

MR. HACKBARTH: David, could you just explain that, a national local medical review policy?

MR. GLASS: There are four DMERCs. Apparently they also have a program safeguard contractor who writes local medical review policy and they all agree on it. And then all presumably put it in place uniformly. So these are still what are called -- they're not national coverage decisions. They're still local medical review policies, but they're all held in common by the four DMERCs.

MR. HACKBARTH: So they're local policies within a nationally established plan and framework that are implemented locally.

MR. GLASS: They're implemented by the four DMERCs, which are not exactly local anyway. But yes, that's correct.

You're going to still need to retain some system to get in provider feedback on what's going on and what are

the new and innovative things, and that's where people raise an objection to this idea of a standard system. They're afraid that if you had a standard claims processing system that you'd have a problem with bringing in innovative new treatments and things like that because they don't want to go through the national coverage decision process. One, because currently it seems to be slow, though that could conceivably be fixed. And secondly, because they don't want one person to be able to say no. They want to have a lot of opportunities for someone to say yes. So that would have to be dealt with.

It has to be dealt with anyway because whatever system you put in place there are going to be claims for new and innovative things actually coming into the system and someone has to make a decision on those. And they have to make a decision on a claim by claim basis for a policy happens, before a policy is developed they have to make a decision on a claim by claim basis.

So someone in the claims processing system, presumably a medical director, will need to be able to have the authority to make those decisions.

DR. LOOP: Don't you think we need to put that

flexibility and that input from providers into this recommendation somehow? Because otherwise, we're going to big brother and we're eliminating all of the local flexibility and input.

MR. HACKBARTH: I'm sure we're going to come back and have a substantial discussion about that issue, but I'd like to hold off on.

MR. GLASS: It is discussed in the text. Anyway, this is the first recommendation.

Given that you've done recommendation number one, we'll come to recommendation number two. This is really to help change the tone of the program, and it's that providers should not be subject to civil or criminal penalties for relying on official guidance that's later found to be in error.

This is a major complaint of providers. Even if they make a good faith effort and do what they're told, they get punished anyway which doesn't seem fair to anybody. So recommendation one sets the stage for making this one possible, because you need to have a well-understood program to make it possible to have official guidance and get it to people when they ask questions.

So in the text we say what constitutes official guidance. It has to be written and CMS is going to have to create a process for providers, suppliers and beneficiaries to request and receive sanctions written guidance on program questions. This could probably be done administratively at the CMS level, or it could be assured by legislative action. This is one of the things that current legislation is considering.

Again, stemming from recommendation one, if the contractor structure is rethought and perhaps the divisions are removed geographically and moved to something else, the administrator of CMS should revisit the proper function of CMS regional offices in the sense that right now, regional offices, one of their roles is through the four consortium, I think, to take care of the local contractors and oversee them. And they have to do Medicaid and other things that really are on a regional basis. So we're saying that you want to rethink what their function is vis-a-vis the contractor world, and possibly also, in regard to beneficiaries, perhaps it could be strengthened if CMS people are put in local Social Security offices as has been suggested in other studies.

Recommendation four. This recommendation to shift the balance toward greater up front vetting of providers and away from back end rigor of claims processing enforcement is a balanced question. I think if you look at the private sector models you'll see that the balance there is somewhat different than currently in Medicare. Medicare has the any willing provider aspect that will let any willing provider in, and then will be very tough on the back end when claims processing and enforcement comes in and weed them out that way. Whereas the private sector tends to be a little more discriminating on the front end. We're suggesting that CMS should do that here.

For DME, for example, just asking for real addresses and Social Security numbers improved that program, which seems like a very low bar to go over.

And beneficiaries, we think, would stand to benefit if they could be assured that providers and suppliers were reliably high quality rather than simply willing. Of course, we just had the quality discussion and how you define high quality will be an interesting question.

In the text we point also that providers and plans might be given credit for good behavior and subject to less

frequent requirements as they exhibit the behavior over the years. M+C plan provider networks, if they've been reliable over many years, why turn in massive documentation repeatedly about who their provider network is, for example.

Again, this is an effort to improve the tone of the program. Providers feel they're subject to multiple audits and investigations from the HHS OIG and from the Department of Justice, various agencies in the Department of Justice. If the current structure is appropriate it needs to be explained better to the provider community. If not, it should be rebalanced. At least you want to make better use of audit and investigation results.

It appears to be within the authority of the Secretary and Attorney General to rebalance and wouldn't need legislative action, except maybe the way the funding comes in, which may be what's determining who does what right now.

Our intent here is to try to slow the pace of constantly changing regulations, and to do so by avoiding Congress having to come back and legislative corrective actions when it turns out the first one didn't turn out quite the way everyone had hoped. So we want Congress to

provide enough reasonable timelines and resources for CMS to develop and test regulations thoroughly before implementation. They may need resources so they can perform tests where that's appropriate. And give them more time so that they can consult with industry and try to understand what will happen as the regulation is put into play.

Now, consulting with industry, CMS may need some exemptions from the Administrative Procedure Act or the Federal Advisory Committee Act, depending on how they want to consult. It's not clear whether they have enough flexibility now to do so.

Here's one, I think, this is simple enough that everyone will agree. CMS should eliminate regulations and other issuances that become obsolete as a result of program changes. For example, CMS should simplify or eliminate cost reports that are no longer needed as we move to PPS systems, simplify or eliminate the ACRP submissions for M+C plans, and basically try to help reduce the data collection burden on the providers and suppliers.

As Murray puts it, we need the equivalent of an uninstall program, where you push a button and all the regulations that you don't need anymore go away when you put

a new one in place. But we don't have it, so CMS needs to figure out how to do this.

The last recommendation, and this is to give CMS the resources to pursue new technologies that would simplify administrative processes and improve the information exchange with program participants. Here we're thinking about things like better use of the Internet for information exchange, put up the statement of policy, have it clearly right there so people can directly to it, they don't need to go through levels of interpretation.

The HIPAA billing standardization may help as that technology goes into place. Electronic medical records might be another technology that if CMS could take advantage of it would simplify things. And also, the information exchange, I'm thinking of tax software where you just put in a couple of data elements and then the tax software does all the complicated filling out of forms and such. And it seems that would certainly be a step that they could take.

That's it for the recommendations.

DR. LOOP: I think in the interest of time, this is probably a subject that everybody wants to discuss, so I'll yield my time to others who want to comment on the

local flexibility and the maintenance.

DR. NELSON: I think you did a great job with this, David, and my comments are with respect to the process for developing the national review policies in the first instance. And then secondly, something that you don't deal very much with in your report and that is a process for updating it or for, in the future, revising it appropriately.

It seems to me that arriving at the national policy in the first instance ought to be done after a thorough review of the local carrier review policies and an analysis of where they're concordant and where they aren't. And then the process should allow for the input of providers and consumer group representatives. I won't use the word negotiated rulemaking process because we don't want something that burdensome.

But at least when these rules are written for the first time it appears to me that there should be an opportunity for input prior to publication as proposed rules. I mean, there ought to be a way to vet it before it hits the Federal Register.

With respect to the process for updating the

policies, I think that also should allow that kind of input. And when it comes to the coverage decisions, I think we should identify in the text the capability or the work of the Medicare Coverage Advisory Committee as a participant in that since they have statutory responsibility for that.

MS. NEWPORT: I'll echo Alan in that you did a very fine job on this. A couple of things that I think need to be clear which might be confusing outside the context of this organization. And I, as always, bring more of an M+C focus to things. But in some of these areas, it appears that the emphasis could be taken as just applying on the fee-for-service side or claims processing as it applies to fee-for-service. But the statements, in the broadest sense, the recommendations, also apply to positions that plans would take in terms of duplication and reliance on advice.

So I think that I would like to be really clear that this has application across A, B and C, and D if we ever get to that. So I think that's just a subtle redirection of the emphasis to acknowledge that. And I think that's important because the plans run into the same situations. Although it may not be claim by claim driven, it is interpretation and the burden that's placed on the

plan. So I'd kind of like to see that emphasized a little differently or declared a statement to that effect, that it's cross-cutting.

Because even in your little intro here, you do say the first three relate to getting -- I lost it. Unnecessarily complication of the program by moving to a standard nationwide system for claims processing. But it doesn't just apply to claims processing, so I'd like to see that clarified.

The other one, and forgive me, I just wanted to go back for a second and not necessarily comment on the specific recommendation. I forgot it. I'll have to come back to it. I'll rest on that point and I'll remember later what's going on. I guess I can claim jet lag today. I appreciate it.

DR. ROWE: It's a senior moment.

MS. NEWPORT: It's a senior moment, yes. Thank you, Doctor.

MR. DEBUSK: Imbedded in this is a major concern from the technology standpoint, because you've really got to understand how the system works now with new technology and substantially improved technology. You know, after a

product is approved by the Food and Drug Administration, ultimately sort of like the clearing process or the evaluation process, ends up at these regional or local levels where maybe a university will work with a local physician working with the carrier or the intermediary. And they'll assign a code to that product. And initially that product is used in that regional area and the efficacy of that product is determined that way.

If you thought about taking devices, of the many devices, of course we know there's a lot of improvements being made in medicine today that are substantial. Stents, implants, hardware and what have you. But if we tried to drive that into CMS, back into Baltimore, that aspect, can you imagine how much resources, what that would require at CMS? And it's already, as we well know it's overburdened.

I understand a standard nationwide system for claims, all this. I can certainly understand there could be a potential of a real plus here. But there's pieces imbedded like this, that there's no way, in my opinion, that we can give up that local input as it pertains to the quality of the devices and what have you.

MR. GLASS: That's a key question. You want some

kind of local input. But on the other hand, that doesn't mean you have to have a local carrier attached to it. In other words, you could have an advisory committee that goes to some medical director, but that doesn't necessarily mean you have to have a local contractor doing it. In fact, the current system of the DMERCs, we have four of them. But even in the Part B carriers we have Part B carriers that are covering 10 or 11 states.

So is it local anymore? I don't know.

MR. DEBUSK: Let me go back. You use the example of the DMERC. So you go to a regional, and I think ultimately what we're going to have is a substantial reduction in intermediaries for Part A going forward. Are we going to assume -- are you saying perhaps a model more like the DMERC on the Part A side?

MR. GLASS: We're not trying to recommend how CMS should reorganize the contractor network. We really can't do that. We're trying to make the simple recommendation that you want a standard system. How they figure out how to get the local input, I don't know. I mean, you could conceivably have advisory committees organized by specialty, for instance, rather than geographically. Maybe that would

make more sense. I don't know. Would it make more sense to have a cardiologist medical director and have him hear from advisory committees that way, rather than do it on a local basis? I don't know.

And as I say, the local basis has kind of evaporated to a large extent anyway.

MR. DEBUSK: Even if it has evaporated to some degree with one intermediary or what have you covering several states, still there's enough of those processing a lot of information as it pertains to the device. And I don't see how we could really give up that piece without really giving up a lot of the development and implementation of new technology.

MR. FEEZOR: I guess I'll test the waters on my newness on this panel. Dave, in your review, was there any evidence that changes either in administration or sort of the political vicissitudes cause for some confusion in interpretation and reinterpretation of regs? Was that an issue? A change in administration where in fact previous regulations are revisited and it becomes a source of confusion for either providers or for participants?

MR. GLASS: That's happening right now. I don't

know if it's a source of confusion but certainly this administration has changed, for the M+C world, has certainly changed a lot of things administratively. Some of which have been, in fact, overturned and it turns out they couldn't do it administratively. So is that a source of confusion? You'd have to ask Janet. I don't know.

MR. FEEZOR: It was just a question more of, if that is, in fact, a point of burden or confusion then the second question -- maybe this is my naivete, is that something that this group wants to highlight or make note of in the report?

DR. ROSS: At the time we talked to a lot of people on this there hadn't been a change in eight years.

DR. NEWHOUSE: I think I'm going to come out on the other side from Floyd and Pete. I found the argument here compelling, that this would be both cut cost and simplify the program for the people that interacted with it.

I understand the argument about we would like some variation, but it seems to me there's variation from the commercial side. It doesn't necessarily -- given that there's a big age difference in the product won't handle that problem. But I found the argument that this is a

national program and an equal protection kind of argument compelling.

As for Pete's point about trials being run locally, trials are covered and one can always authorize coverage under a trial in some setting or other without making a national coverage decision. So I don't find that an important argument, unless I'm missing something.

But I know our friends at Pharma and Envomed have sent us letters touting local coverage decisions. I just find the balance goes in a national program that there should be uniformity of benefits insofar as we can accomplish that.

DR. STOWERS: I've got a couple points, and one goes back to what Pete was talking about. I'm totally in support of what is said here about eliminating local descriptions of policy and regulation. But I would add some words in there maybe to kind of bring us together. Something like while allowing for local flexibility to initiate new and innovative ideas and technology or something like that. It would still get across the point that there needs to be some way in the system.

And that kind of gets to my second point, and it's

a great chapter. But I don't think we emphasize enough in the chapter how much responsibility, if this all happens, is going to come back to CMS as a central agency and uniform agency, and what the responsibility is going to be at that point for Congress or whoever to provide a large amount of resources, that's going to run a central billing system, and that's going to put out this information across the country, that's going to take on bringing new technology into the forefront in a more timely manner, which obviously is a huge problem right now, to try and do that on a national level.

I think we really need to emphasize in this chapter that if we're going to make these changes and we're going to centralize all of this, that there's a lot of resources and money involved in doing that. We kind of do that, but I...

DR. NEWHOUSE: Ray, I think there's less money involved.

DR. REISCHAUER: It's in somebody else's hands, but there should be less because you don't have it going on in numerous duplicative agencies.

DR. STOWERS: I think what I'm trying to say is right now it can take months and months and years. As you

said before, that can be fixed. But it is going to take an overhaul of the way CMS has done some things to get national cover policy and that may require new technology. I personally think the overall cost will be less but it's going to take a tremendous shifting of where the money is spent to make that work. I'm just not sure that came across, that there's going to be an inherent responsibility to do things a lot different at the national level and to give them the resources to do that.

DR. REISCHAUER: And we could say something about speeding up the process. This has been a problem with intermediaries already.

DR. STOWERS: Absolutely. Because the current process, if we were to just do this tomorrow and not change the current process at the national level, this would be a disaster. And I think we really need to make that point about that.

MR. MULLER: One of the questions I had was whether the standard nationwide system of claims processing necessarily implies one claims processor nationally?

MR. GLASS: No, it would not.

MR. MULLER: But it may in due time, to get that

kind of standardization. One of my concerns -- you have some variation right now. So I would make two points. One is I would be very much opposed to one, if you could create such a beast, having one claims processing part. You'd never be able to replace that entity because of the all or none situation in terms of coming in.

And secondly, and this is kind of similar between draft recommendation one and two, I think while in a negative way we say that the provider should not be subject, in recommendation two, criminal penalties for relying on official guidance. I think insofar as the carriers are official agents of CMS and the Medicare program, then there has to be full responsibility for what that agent does. I'm glad to have this recommendation. But there should be responsibility for what the carrier does on behalf of CMS, as opposed to just saying they're a contractor and we can selectively stand behind them and not stand behind what they do.

One of my concerns is, given the unevenness of the carriers, they do make mistakes along the lines you indicated both in your oral conversations today and in the report. But we need to really have CMS be responsible for

its carriers on a full basis at all times, as opposed to just having some distance between CMS and the carriers.

Let me just go back. Bob quickly said that there would not be a standard nationwide system of claims processing. How do you envision then getting the kind of standardization you're looking for? By just broader regionalization?

DR. REISCHAUER: No, I said there wouldn't be a single contractor, that there would be probably a handful and I think there would be an interest by CMS to keeping a competitive environmental alive, just as we do for fighter aircraft and ship building in the Defense Department.

MR. HACKBARTH: But they're all using the same software and the same rules.

DR. REISCHAUER: Same software and the same rules.

DR. BRAUN: I just want to say, I do strongly support this and I think that it will be -- I understand the innovation problems but I think it will be -- new technologies get old and I think you have tremendous differences. I think the process of looking at this whole thing will bring out the differences from area to another and what's covered. It just keeps coming up again and again

if one knows from one area to another, things that are covered.

Just last week I encountered a patient with peripheral neuropathy who needs a special shoe with an insert in order to get this ulcer healed on her foot which she's had for a very, very long time. And I found that in Florida that's not paid for. Now that is paid for up in the Boston area. It's paid for in the New York area. It makes no sense at all that it's not paid down there.

And it's not local medical practice. The local medical practice is nationwide that these are used, but it's just coverage practice that differs. And I think that will turn up in the process of getting to this point.

DR. LOOP: Joe, I'm not sure we're opposites here. Maybe I didn't state my case here. Let me start with recommendation two and then jump back to one.

The big problem, if you're on the provider side, is that you can't get guidance. In fact, the intermediaries won't even give it to you in writing. That's a big problem. So in addition to improved efficiency by moving to a standardwide system of claims processing, you should be able to get standards in determination, that is translation and

interpretation of guidelines. That's the good part.

But if you just think about it, there has to be some kind of input to this centralized CMS claims processing by the provider community. And if you don't have that, then they act with ultimate authority with no input and it becomes another bureaucracy. That's what I'm worried about.

So what I want is some kind of an advisory board that --

DR. NEWHOUSE: They have it.

DR. LOOP: They do?

DR. NEWHOUSE: Medicare Coverage Advisory Committee, which is the mechanism for reaching a national coverage decision.

DR. LOOP: Fine. If that suffices, then...

DR. NEWHOUSE: It's somewhat cumbersome, as people said.

DR. LOOP: Is that staying? Is that in effect, and will that be in effect with this move to a standard claims system?

DR. NEWHOUSE: I would have thought so.

MS. ROSENBLATT: Let me mention that my employer, Wellpoint, was a fiscal intermediary in California, is no

longer, and is currently a fiscal intermediary in Georgia. So take my comments with that background.

I, unfortunately, don't know a lot about the fiscal intermediary program. I haven't had a lot of contact with it. So some of my comments may reflect my ignorance.

But in talking about a standard nationwide system I think that that does have the aura of reduced costs. But getting there has enormous costs. And I don't think there's enough in here about how difficult a change like that is.

But on the other side of that, when I hear people who are intermediaries talk about it, they talk about the Florida system. So I don't really understand how close we are right now to a common system.

MR. GLASS: I think there are the so-called standard systems, of which I believe there are two for FIs and four for carriers. So those are common -- those are standard software systems. There's a vendor for them and each of the contractors has to get that software system from the vendor. When there's a regulation change, the software vendor of the standard system has to put it into the standard system. Then these things end up at the contractor.

MS. ROSENBLATT: It sounds like you're saying there are four standard systems?

MR. GLASS: Yes, that's an interesting phrase, isn't it? Four standard systems. I think that's in the carrier world, I may have these turned around.

MR. HACKBARTH: Those four systems vary in content? They're substantively different, in terms of the results that they produce?

MR. GLASS: Is the basic logic behind them different? I don't think it's supposed to be. I think if you put in a claim at one end, you're supposed to get the same answer at the other end. Yes, Word and WordPerfect. So the idea is that they're supposed to be the same. The problem is that if you've ever done coding or programming, that's not so easy to accomplish.

MS. ROSENBLATT: I guess my point is that maybe some background on what is there would be helpful, and then some narrative on how difficult it is to combine systems. Working for a carrier that has bought companies and tried to bring systems together, it's the most difficult thing in business I've ever seen. It's extremely difficult, extremely costly, and I think we need to recognize that. I

think the goal is wonderful, but I think some narrative about how hard it is might be worthwhile. That's on recommendation one.

The other point I wanted to make, on recommendation two, and again I'm not an expert on this, but I'm getting the sense that there is some proposed rule or legislation out there that would impose additional liability on the fiscal intermediaries? I'm hearing talk that carriers are saying maybe we should no longer do this if there's going to be additional liability. I didn't see any mention of that.

MS. LOWE: There's two pieces of legislation that we discussed earlier that are out. Each of those bills has different provisions about whether or not contractors will have to provide written guidance or whether they can provide written guidance.

Associated with that then is the responsibility of providing correct guidance. I think that is probably what is at the root of some of this concern.

MS. ROSENBLATT: So we need to, in addition to talking about providers should not be subject to civil or criminal penalties, is there a similar statement for

contractors?

DR. ROWE: You mean fiscal intermediaries?

MS. ROSENBLATT: Yes.

DR. ROWE: There's a long history of their paying huge fines. Illinois was hundreds of millions of dollars, I think. So if you want to put in a provision that they be immunized against that, that would be...

DR. REISCHAUER: It might not be the end of the world if you went to this new system in which every three or four years we recompeted and presumably those who have been willfully negligent or incompetent would be bounced out. But it's sort of been an inheritable right, at this point, to run one of these things. So you need some kind of disciplinary effort.

DR. ROWE: The point I was making is, I'm very sympathetic with the idea of immunizing fiscal intermediaries. I think that we could never go there because in many ways the fines are designed to recover funds that are felt to have been overspent, overcharged, et cetera, et cetera. And you can't take away somebody's ability to do that, I would think, or the government's ability to do that.

MR. MULLER: Can I just come back to the point that Alice and Bob were talking about, and Alice made it better than I did. But my experience with these computer systems are like the languages in the Indonesian valleys. They're all different languages and nobody speaks to each other.

So the sense that even if you have standard systems, I really question to what extent standard systems are really standard. If one, for example, ran 1,000 claims through the various intermediaries and carriers around the country whether one would get 100 percent equivalency in terms of how it's processed, 90 percent, 80 percent. I don't know what the right number would be.

But if it's something like 80 percent, that would be a pretty unwelcome outcome. I'm just putting a hypothetical out there. I don't know what the answer is.

So as one thinks about integrating these computer systems that go towards a more standard model, I have the question of who's going to bear the cost, how they'll get integrated, whether in fact -- as Bob suggests -- every three or four years -- it's hard enough to get people to invest in these once every 25 years, let alone every three

or four, given the number of old systems we have in the health care world.

So one of my questions is exactly how does this standardized system of claims processing come about? Now if I'm wrong, again like Alice I don't have as much familiarity with this, but in the parts of the world I do know in health care the systems never talk to each other. So the question is are these systems really as standard as the comment as there are now six of them right now implies?

MR. HACKBARTH: I'm getting confused. Maybe I never understood it to begin with. I assumed that the starting point here was that, in fact, there is variability in results. That's the problem that we're trying to solve.

So although there are four standard systems -- is that for the carriers or the FIs?

MR. GLASS: I think that's the carriers.

MR. HACKBARTH: Okay, let's stick with that. There are four standard systems for the carriers. They are producing significantly variable results.

MR. GLASS: It goes beyond that. See, there are four standard systems --

DR. REISCHAUER: That has nothing to do with a

standard system. That has to do with decisions that are made on how to cover different things in different areas of the country. We're talking about two very different things. One is sort of the software and let's say we go down to 10 entities which process claims. Do they all use the same software? Or are there two or three different softwares that are approved to be used?

But then there's the second question, do they all use the same rules? That's what we're talking about.

MR. GLASS: In addition to the four standard systems, then the carriers put in their own automated edits, which are supposed to be supported by LMRPs. So you can get a lot of variation.

MR. HACKBARTH: I think maybe what we need to do is start going recommendation by recommendation. 90 percent of the discussion has been about one, but we do have other recommendations that we're going to get to.

So let me ask if there are any further comments about one?

MR. DEBUSK: Murray, maybe you and Joe will know the history of this. Within the DMERC side, at one time was there not 28 or 32 DMERCs? How many were there?

DR. ROSS: I don't know.

MR. GLASS: It used to just be one of the carrier functions and you got a Part B carrier that did, among other things, durable medical equipment.

MR. DEBUSK: But they processed it in different locations? It come from some number all the way down to four, right?

MR. GLASS: They decided to specialize, four of them, specialize and put it in four places.

MR. DEBUSK: And they're on one computer system, they're on the VIP system and all the claims go through there. They're going through there at this point so let's standardize -- there's four medical directors. Now let's look at the fiscal intermediary, and I just want to make one more comment.

If that's where they're headed, and I understand it is, EDS I think is ultimately the system they're going to or trying to merge toward. If we end up with a smaller number of FIs and the standardization takes place in this manner, ultimately within those regions that will be left, if there's someone or some relationship to process new technology this could make sense. But if all of this is

going to funnel into Baltimore, it's a big train wreck.

MR. HACKBARTH: I have a comment about number one. Some of the language seems pretty absolute to me. Eliminate any local descriptions of policy and regulation. I wonder if maybe what we're trying to do is allow variation only when it's a conscious exception to a national rule with the idea that the goal is to have national consistency and uniformity, but sometimes we may want to allow some local variation on a temporary basis to learn things and then make a decision whether or not to move it into a national system.

DR. NEWHOUSE: Why would we do that outside of trial?

MR. HACKBARTH: Whether you label it a trial or not doesn't really matter to me.

DR. NEWHOUSE: It matters to whether you're going to learn anything.

MR. HACKBARTH: The problem with the current system, as I see it, is we have sort of uncontrolled variation. It's just willy-nilly variation based on local factors. I think of running a large organization. Often you want to delegate things. You want to have some local flexibility. But when you delegate well you delegate within

a framework and a sense of how it fits in the bigger picture. I don't think that's how the current system operates.

MR. GLASS: The thing is, depending on how they do the contracting for this, what would local mean? I'm not sure what local would mean anymore. I'm not sure what it means now, to tell you the truth.

DR. REISCHAUER: What it means now. What it means now is geographically arbitrary.

MR. HACKBARTH: But even if you have a system of national processing through a small number of contractors, you could say in a particular geographic area there seems to be a lot of interest in a particular innovation. And in that area we're going to try some coverage, label it a trial, and make a decision about whether that ought to become a national decision.

As opposed to saying it pops up in this locale. The only way for something to happen is for it to go through the national coverage process.

MR. GLASS: You're going to have medical directors -- whoever is processing the claim, they're going to have to have medical directors. They're going to have to have

people making decisions, and sometimes on a claim by claim basis, for what to do with new things that come in. So I think that has to be retained. I don't think we should tell -- well, I don't know that we can recommend to CMS how to do that. We can certainly reword the recommendation, but I don't think we're ready to tell them how to do it. But I'd like to leave the word local out of it.

MR. HACKBARTH: My point is not to tell them how to do it, and I'm not wedded to the term local. But what does seem important to me is that it may be appropriate to have variation with an idea of bringing it to a national standard, as opposed to the current system which has sort of permanent uncontrolled variation. That's what we're trying to get away from.

MR. GLASS: As Joe said though, it would be nice to learn something if you do have a provisional coverage decision, it would be nice to learn what the outcomes were, which I don't think --

DR. REISCHAUER: I think people are trying to have it both ways, and I don't think you can. But what we might want to say is, to the extent we move in the direction of these recommendations, CMS has to place a greater priority

on demonstrations of innovative coverage, procedures, devices, whatever. The time frame has to be shorter for these things and we have to look more carefully.

DR. NEWHOUSE: How is that different from the FDA trial process? There's processes over in the FDA for approval of devices that rely on trials. And Medicare now covers trials, as I understand it. So I'm not sure what the issue is here, beyond the uncontrolled variation.

MS. ROSENBLATT: On this point, I have another question. Do you know how much, within any of the four or six systems, how much is system adjudicated versus doesn't go through the system, requires manual intervention to pay a claim?

MR. GLASS: I think something called a clean claim, which wouldn't trip any of the automated edits, I think it's like 90 percent of the claims. Or clean claims don't trip any edits and don't get pulled for medical review.

MS. ROSENBLATT: So 10 percent of the claims are still going through a manual process?

MR. GLASS: That's an approximate number, as far as -- I'm not sure.

MS. ROSENBLATT: The point I'm trying to make here is, we're talking about consistency and how you get there. But I don't know any claims system that's able to process 100 percent of the claims automatically. The minute you go through a manual process you introduce differences. So I guess to the discussion that was just occurring that's a point.

And also, again going back to my point before of the cost of getting there, we could spend a lot of money to get to a consistent system and still not achieve the goal of consistency, depending on how much has to go through that manual process. So that's an important point.

DR. REISCHAUER: I think what we're talking about is Bea's problem: are the shoes covered or aren't they? And why shouldn't they be in Florida if they are in New York and Boston and most of the country? That's what should be consistent. Then there will be sort of a lot of judgment calls around the edge of the sort you're talking about in any system.

MS. RAPHAEL: When we say systems here, I think it's a proxy for some kind of consistency in decisionmaking and the rules of the game.

MS. ROSENBLATT: The point I'm making is that paying health claims is so complex that doing all of that coding, you don't get to 100 percent. That's the problem.

DR. ROWE: I think that I agree with what Alice says, although I think that there is one risk in generalizing from our experiences in a non-Medicare world. And that is one of the major problems in handling claims for Wellpoint Health Networks or Aetna or PacifiCare, is that we have a lot of different products out there. And every plan sponsor has got a different set of what's covered. The benefits change a lot.

So when a given person is calling in and that person may have moved from one company to another or, within a company, from one plan to another. What's covered? What isn't? What's the timing, et cetera?

A lot of that complexity which, for us, is very expensive and burdensome, is not relevant to the Medicare program. So that we should recognize that you'll never get to 100 percent, or the cost goes dramatically up as you try to get to that 100 percent. But that some of our complexities really aren't inherent in the Medicare program.

I think the other thing that we have to understand

that I haven't heard, and I'm not sure it's even our role, is that there are tremendous variations in the practice of medicine across the United States. And this variation is not all bad. It's related to practitioner preferences and beneficiary preferences. There are different rates of utilization of different kinds of medical interventions, surgical interventions, et cetera. Some of it is noise and bad and Jack Wenberg and his colleagues have taught us about how that's not good quality.

But there's some of it that just is inherently there. And the market is different. In some markets you have more providers than you need. In some markets you have fewer providers than you need. And I wonder to what extent these variations in the health system, independent of Medicare, drive some of these differences that we are seeing or whether or not they would all be washed out? And whether or not that is a consideration or not. I don't know if it is or not, but it might be.

MR. HACKBARTH: Any response to that?

DR. REISCHAUER: You could have made a case for that a number of years ago when the intermediaries, the carriers, were geographically identifiable. But now it's

tough to make.

MR. HACKBARTH: Any other comments on recommendation one?

DR. NEWHOUSE: When are we going to vote?

MR. HACKBARTH: Do you think we ought to do it as we go through right now or go through all of them?

DR. ROSS: I think we've been through all of them.

MR. HACKBARTH: Well, we haven't had much comment on anything other than recommendation one, at this point.

DR. ROSS: I took that as agreement.

MR. HACKBARTH: Why don't we start going through discussion and vote on each one. The issue on the table is draft recommendation number one. All opposed? Raise your hands so I can see.

All in favor?

Abstain?

Okay, should we go on to number two? Comments on number two?

DR. NELSON: I agree with this recommendation, but I would like to see the words inserted after penalty, or be required to replay "overpayments" when relying on official guidance and so forth. The reason for that is one of the

things that's driving people crazy will be they'll ask for instruction on what to bill for or whatever, they'll receive what they think is clear instruction and then subsequently be informed that it wasn't covered. It may not be a covered service. It may be that they'll ask for a coding level, a level of service, and be told one thing and then subsequently be forced to repay not only that, but if it's extrapolated, a bunch of additional claims.

So it's not common -- as a matter of fact it's relatively uncommon -- for civil or criminal penalties to be levied on this. But it's very common for overpayments to be requested back. And when those overpayments were based on clear instruction from the Medicare program, then that should not be required.

DR. ROSS: Are those overpayments really in the same category as the civil penalties though? One is punitive and the other is after the fact we determined you supplied a different service than we thought. I'm asking that as a question?

DR. NELSON: They're in the same category in that they are an inappropriate, in my view, consequence of following instructions that you thought were clear. And if

you do a substantially greater piece of work based on your instructions and then find out that you don't get paid and have to turn the money back, it's in appropriate.

MR. MULLER: They have both components. For example, if there was a finding later that there was some combination of over and underpayments -- and usually both occur -- it would be a calculation of that. And then depending on what was seen as the reason for it there may then be a civil and criminal penalty on top of that. But it's the same finding around a claim or a set of 1,000 claims, et cetera.

MS. RAPHAEL: I think that I agree and understand this recommendation, and I also agree with what Alan modified in this recommendation. But I think there is another issue which is imbedded in the text, and I don't know if there needs to be a recommendation or it needs to just be highlighted even more. But I think a central problem is that you can't get guidance. It isn't only that sometimes you get guidance and you act on it and therefore you get burned because of that.

But I think a more central issue is that you can't get any guidance. And this really harms the beneficiary as

well as the provider because you don't know at the outset whether what you need and are prepared to provide is going to be covered. And I think that is a difference between Medicare and the private sector because in the private sector you can at least find out what is covered.

So you're sort of flying blind.

DR. REISCHAUER: They say no rapidly?

MS. RAPHAEL: They say no rapidly rather than three years later you find out that it wasn't covered.

So I don't known whether or not there's any thoughts you have, David, about this issue. And I know it blends into this ABN and all of the intricacies of the ABN and the confusion that that breeds in the program and sort of the distrust between the provider and the consumer of services, but I just think that is a central issue.

You have to make decisions. I mean, we have cases in hospice where someone comes in with a prognosis of six months and it turns out all of a sudden they're recovering and you have to make a decision. You can't really confer with anyone about how to handle the case, if they're going to really have a different prognosis at this point.

MR. GLASS: We brought this up in the text, the

question of prior determination and why give people advance beneficiary notices and say this may not be covered? Why not make it so that they can find out? But we didn't bring it to the level of a recommendation and Marian says this is actually in the current legislation.

MS. RAPHAEL: It is?

MS. LOWE: This is one of the areas where there's some key differences between the Commerce Committee bill and the Ways and Means Committee bill that are being worked out right now, whether or not contractors are going to be required to provide written guidance within a specified time period or whether or not, if they do provide it voluntarily they will be held to it.

That's one of the more contentious issues and I think a lot of debate still about what is the appropriate role. And given that we don't have a standard system, frankly the ability of contractors to be responsive and be accurate under this very great variation that we have right now.

DR. ROWE: I'll made the same comment I made the last time we discussed this chapter and that is that I think this recommendation is meaningless in the absence of a

definition of official. It doesn't indicate whether this is verbal or written.

MR. GLASS: Actually in the text we did try to --

DR. ROWE: In the recommendation it doesn't say it. It says relying on official guidance. I think that if you want to make it written, it should say so in the recommendation. Otherwise, the recommendation is the recommendation. And I think that these verbal communications -- our experience is that these are a complete nightmare. I mean, we have had experiences where, in one state, we're bound by verbal guidance. And if a doctor calls and says I'm going to do an operation on Mrs. So-and-so, is that going to be covered and somebody says yes. And it turns out that Mrs. So-and-so wasn't an Aetna customer but we still have to pay because it was "official guidance."

So I think that we have to be very specific here or people will jump all over. And if it's verbal, then who said what to whom? Unless it's recorded, how do you know what was really said?

MR. GLASS: Jack, in the text we say, we use the term "official guidance" to mean written rather than oral

direction from the program.

DR. ROWE: I understand, I heard it, I read it. I think the recommendation is meaningless without written --

MR. GLASS: You want that in the recommendation itself?

DR. ROWE: Yes, because otherwise so what about the text? I mean, there are a lot of stuff in the text.

DR. LOOP: The problem with just inserting the word written, though, is then they won't give you any written guidance. They'll all be verbal because you can't get any written guidance now. So official has to be --

DR. ROWE: But if you're saying -- if the point that was being made by the esteemed staff was you're not changing anything by putting written in there, Jack, because that's what we meant, then...

DR. LOOP: Then you have to say, all guidance has to be written, to make it official.

MR. HACKBARTH: It comes back to Carol's point, are they required to provide guidance or not? I think one of the problems with the system right now is people feel like they cannot get guidance and that feels burdensome. It is, in fact, burdensome if they turn out to make a wrong

decision.

So I don't think just adding written really changes anything for the reason that Floyd --

DR. ROWE: I'll try something else then. That is on Alan's point about returning overpayments. This says, providers should not be subject to civil or criminal penalties for relying on official guidance. I think not everyone would interpret that as it doesn't mean you have to pay back something if you were overpaid. That's not a penalty. That's paying back what you were overpaid. A penalty would be an additional fine or treble the case or something. That's a penalty.

But this still says, and I think it should say and we should understand it to say, that if you were overpaid something you should pay it back. There's no extra penalty for having been overpaid and paying it back. But you should pay back what you overpaid. That's what I think this says.

MR. HACKBARTH: So you're agreeing with Alan that we ought to add --

DR. NELSON: No, he's disagreeing.

DR. ROWE: I'm just showing you how this could be interpreted.

DR. NELSON: If I can respond, it says criminal penalties or be required to repay overpayments. And it's not that --

DR. ROWE: My copy doesn't have that.

DR. NELSON: If, indeed, the service was delivered based on official guidance. And overpayments are often extrapolated to the degree that they do amount to penalties. And further more, you call somebody, you get a response, it's supposed to be official. You go ahead and do what the patient needs and then subsequently somebody says you have to pay it back. We're not talking about whether they wrote a check bigger than they should have. You billed what you were authorized to bill and then retrospectively they want it back. There's a difference.

DR. REISCHAUER: But isn't the issue often the context in which the service is delivered? And in this communication, the CMS person or the contractor might not have all the information. Later on, when the full bill comes through with all the other procedures associated with it, you realize that this was really bundled with something else in this kind of system and so we have, in a sense,

overpaid you.

DR. ROWE: Why is MedPAC even bothering with this anyway? Isn't this a little below the level that we're supposed to be -- it depends on how much information is provided. I'm not saying any providers would ever purposely mislead. Perhaps not all the questions were asked in this verbal communication that we're apparently approving. And so the person didn't understand that putting the urinary catheter in is, in fact, part of doing this operation anyway and no, it wouldn't be paid separately.

MR. HACKBARTH: The IRS, as I understand the process of revenue rulings, they make rulings, written rulings, and they're quite specific about the factual context. And if, in fact, the facts turn out to be different, the ruling is not binding on the IRS.

And so if CMS were to give a written opinion, which they based on these facts and if, when the claim comes through the facts were different then, of course, it wouldn't be binding on them.

DR. ROWE: I agree.

DR. STOWERS: I just want to echo what Alan is saying. We've had some small providers, especially smaller

hospitals, who had written guidance, get five years down the line providing service to that community and so forth, and then come back and have huge amounts of money that they've been paid, especially in the rural health clinic arena. And they based their budget on that and then suddenly there's a huge payback. It can be devastating to these smaller providers. So they may have the resources to change the course of therapy or services that they've been delivering over a period of time suddenly because now the payments are going to be different, or were different and they have to pay them back.

So it can be devastating to small providers to have planned their care over a period of time and then somehow they can't take it back.

MR. HACKBARTH: I think to make this recommendation a meaningful one you have to tie these pieces together. I think that there needs to be a requirement that they make decisions. And if you ask a question, they have to answer it. Answer it in writing and if then they try to renege on it, they can't renege on it. And that means criminal, civil penalties, or payback. But it's very specific to the factual context.

MR. MULLER: So we should put that language into this.

MR. HACKBARTH: And I think that's what makes it a substantive recommendation. If you leave out any of those pieces then it's just full of holes and it doesn't really change the situation.

DR. LOOP: I just have a question for my own edification. Is the official guidance then going to be taken over through the centralization of the national system of claims processing? I mean, is the guidance component going to be transferred centrally to CMS?

MR. HACKBARTH: I think what we want to do is avoid, so far as possible, saying exactly how these things ought to be done mechanically. But certainly it's in the spirit of the first recommendation that you ought to get uniform answers regardless of where you live.

Now whether it will be done in Baltimore or through a contractor located in Lubbock, Texas, we ought not get into. But you ought to get consistent answers regardless of location.

MS. NEWPORT: I know this is a minefield, but what I really am concerned about is there's written

interpretation given to health plans that affect their payment as well as the payment to the contractors, identification of institutionalized members. So I want it clear in the text that it applies to payment of providers across the board and not that there's an emphasis here on claims processing. There are other implications.

I'm just trying to make that symmetrical in the text. That may be providers by definitions, anyone who is contracted in some way, a participating provider in the system, has the same rules apply to them.

DR. NEWHOUSE: I want to, like Jack, go back to a point I made last time that I think might belong with this recommendation, or maybe it should be a separate recommendation, or maybe not at all. But it goes to the issue of extrapolating from a small number of incidents.

I would have some language that could be expanded in the text about use of modern statistical methods to ascertain total overpayment rather than simple extrapolation from a small sample to do so, is something that we would recommend.

MR. HACKBARTH: An actual recommendation or in the text of the recommendation?

DR. NEWHOUSE: It could go in the text, but I think actually I would personally make it a recommendation because there's, rightfully, concern out there about extrapolating from a small sample. The analogy I made last time was extrapolating to the baseball player's end of season average from his first 10 at-bats.

MR. HACKBARTH: But given the scope and nature of the other recommendations, it seems awfully narrow for a recommendation.

DR. NEWHOUSE: I'm happy either way.

DR. REISCHAUER: I'm wondering what the relevance of it is, if we're saying no civil or criminal penalties?

DR. NEWHOUSE: This goes to Jack's distinction between penalties and repayment of overpayment. And then the issue is how the overpayment is calculated if we determine there's been overpayment.

MR. MULLER: But if we add the overpayment as not be subject to it, which I understand Alan's point to be, that at least there's a recommendation on the floor.

DR. NEWHOUSE: So maybe we have to reach a prior thing on that, because I'm actually with Jack on this point, that if it's overpayment it should come back.

MR. HACKBARTH: Number three?

DR. ROSS: We'll recraft and bring back two.

MR. HACKBARTH: The changes we're talking about are such significant amendments, we ought to vote once we have the new language.

MR. MULLER: Can we get some sense of whether the overpayment is in or out, because there seems to be a big difference of opinion on that.

MR. GLASS: If we're going to rewrite it, we have to know whether you want to put the overpayment in or out.

MR. HACKBARTH: Here's my proposal again, is I think that the several ideas that have been stated need to be brought together. I think there needs to be a requirement to answer questions and there ought to be a written response that's then binding with regard to civil, criminal and repayment, is the way I would suggest we word it. I think those pieces all fit together.

DR. NELSON: There's no consequences for bad information.

DR. NEWHOUSE: I don't have any problem with that. I guess my point maybe then should be in the text but it's beyond this, because there's other instances where I didn't

rely on official guidance and I'm determined that I was overpaid, and how that's calculated.

MR. HACKBARTH: So that's what we're looking for in terms of a redraft.

Number three?

DR. LOOP: When I read this, considering the first two recommendations, I wondered why we even needed recommendation three. But Bea has since educated me that the regional offices do more than just what is described in the first two. Maybe she wants to comment on that.

DR. BRAUN: Just to comment just to say, I was going to give David, or perhaps he has -- I think in the text we probably ought to elaborate on some of the functions that the regional offices have besides those that have to do with providers. There are a whole list that I have and I was going to give them to David for putting them in the text.

So that's the reason that this is worded this way. They need to look at the function rather than say that the regional offices should be eliminated, because they have a lot of other functions.

MR. HACKBARTH: My reaction was similar to

Floyd's, that this just didn't seem like it needed to be in a recommendation.

DR. ROWE: It's really gratuitous. There are other functions so irrelevant of one or two, so they'll be there serving these other functions.

DR. BRAUN: I guess the question is is anybody talking about the fact that they probably would be eliminated with the --

MS. RAPHAEL: What are their functions?

DR. REISCHAUER: Is this a huge portion of their functions or 20 percent? My guess it's --

DR. ROWE: It's not all or none. So you scale it back but it's still there doing these other things.

MS. NEWPORT: It depends on what part of the program you're in, for example. I think they don't even know right now what they do because it switches about every three years, depending on new administrators.

MR. HACKBARTH: The recommendation doesn't say that they ought to be eliminated. It says that we ought to revisit. This reminds me of the recommendations when we say the secretary shall monitor or -- there's really no content there to support a recommendation.

MS. NEWPORT: I don't have a problem with taking this recommendation down. I think the text leaves the impression that we are saying eliminate the regional offices, and there's all sorts of other issues out there that go to that. I think if the broader recommendations play out the way they should, the structure and processes that are imbedded, rightfully so, in the regional office would be improved. That's very optimistic, but there's hopefully some logic to that.

There are huge debates that rage within the M+C program about what is the proper function of a regional office, which always revolve around weaknesses and inconsistency in interpretation from what happens at central office.

The analysis here isn't probably at the level it should be to be appropriate and we might want to just save space or take this down or acknowledge rightfully that it is integrated in approved processes, improvement to the regional office functions.

DR. REISCHAUER: I guess I think a lot of the text can remain but the recommendation should be dropped.

MR. GLASS: All right.

DR. NEWHOUSE: Why do we want a recommendation that appears with a vote in our report? Why should we even have a vote?

DR. ROSS: Is there anyone who objects to dropping the recommendation?

MR. HACKBARTH: So it's a straw vote as opposed to a formal recorded vote.

MS. RAPHAEL: I just have one question. I don't know the functions of the regional office, but David, is there an issue here that the regional offices have a similar situation as the carriers and the FIs, that they contribute in some way to some of the inconsistencies and to differing sets of rules?

MR. GLASS: I think that's probably true on the M+C side more so.

MR. HACKBARTH: Does anybody object to our taking out this recommendation?

DR. NEWHOUSE: And leaving in text.

MR. HACKBARTH: And leaving in text.

DR. BRAUN: I would stay ask though, if there is going to be text left in, that it be added to so that there are evident more functions.

MR. HACKBARTH: Number four?

DR. NELSON: I agree with the concept. I'm a little disturbed that the implications might be to increase the burden of enrollment and re-enrollment which is already a problem. And we're talking in this chapter of lessening the administrative burden. If there's some way to imply that we're talking about a balance in the zero sum thing, I'm happy with it. But I'd hate to add to the administrative burden through this recommendation.

I don't feel so strongly enough that I want to delete it. I'm expressing a concern that needs to be accommodated. Maybe it can be in the text.

MR. HACKBARTH: To me this seemed a bit like apples and oranges. The front-end vetting tends to focus on, for lack of a better term, their structural characteristics, whereas the back-end review tends to focus on their behavior. If we have front-end review of their ability to produce quality of care, what does that really say about their behavior in terms of how they bill the program?

We could have really high standards at the front end and they might engage in questionable billing

activities. Why is there a trade-off between these two? See what I'm asking, David?

MR. GLASS: Yes, I understand the question. I guess we were thinking that in the private sector there seemed to be more emphasis up front on who joins the network and that sort of thing, but we may be mistaken.

DR. ROWE: First of all, I think in the private sector there is not more attention paid to who joins the network currently, as compared to what it used to be. The networks are very broad, very, very broad. What we have is managed care lite, networks are enormous. So I think there may be tiered networks in which there are some tiers that are more tightly scrutinized, but in general no.

I don't like this for a couple of reasons. One is I think it kind of gives the feeling, at least the language that the staff has about one approach to solving the problem suggests that we're letting bad doctors in or something, which I don't think I like at all, because I don't think that's the case.

Secondly, I don't like the language about enforcement because I think that connotes something other than what we're trying to do. This is a chapter on reducing

regulatory burden and we've got language in here about fraud and abuse and enforcement. It just seems to me to be not where we should be going. It would seem to me that if this is a chapter about regulatory burden, and if we need to have a recommendation with respect to this, that it should be something about that efficiency can be enhanced and regulatory burden reduced by a greater emphasis on prospective advice or something like that, rather than retrospective decisions.

I think that would be more in line with where I think we want to go.

MR. GLASS: Part of our attempt was to try to figure out a way to provide rewards for good behavior over the years. That doesn't capture it.

MR. MULLER: One of the reasons for the burden, I understand in part, in general is that we have to have very comprehensive rules to get whoever those bad apples are, however few they are. We have very comprehensive rules that everybody gets hit with so we get to the few bad apples. In that sense, it creates regulatory burden for whatever that is, 80 percent, 90 percent, 98 percent of the ones who tend to comply in order to get the 2 percent, 8 percent, 10

percent, whatever those estimates are, of the ones who are not engaging in appropriate behavior.

So I think part of the sense of this, and maybe I agree in some sense, it may be hard to have up-front vetting of providers at a time in which more and more people want to let the marketplace determine who comes into the providing of health care. But I do think some sense of if we could be more efficient in how we pick out the bad apples -- and I don't know exactly how to do that -- but I think that's part of the reason that a lot of people think there's a lot of regulatory burden, is that by having national rules and administrative procedure acts and all kinds of appropriate fair process, it becomes very hard to get the bad apples out.

Even the ones we do know, it seems to take an undue amount of time to get them out of the program and therefore, in that sense, it burdens those who are trying to engage in appropriate behavior.

MR. HACKBARTH: The concept that to me seems to make sense is there ought to be less scrutiny of people that have sustained records of good performance. And I think the connection to front-end vetting is not right. The sustained

good performance doesn't happen at the entry point. This is something earned over years in the program.

So I could support something along those lines. But it comes very broad, very conceptual, as opposed to --

MS. RAPHAEL: I agree with you. I think that the issue here is that every time there's an incident you get new regulations to try to prevent that incident from occurring and that adds to the regulatory burden on all the people involved in the program. But I agree with Glenn, and I think this is controversial. But thinking about some differentiated level of review or handling, depending on performance, is really what the issue is here.

DR. ROWE: I would give an example, and I think that would recast this significantly. NIH had this same problem some years ago and they came up with a very good solution. They wanted to reward the really good investigators and make it simpler and more efficient. And they really couldn't pay them more because the cost of the research was the cost of the research, they had a budget.

So they said okay, we're just going to give you longer grants. So if you get X number of priority scores and you're in the top 10 percent X number of times, your

grant automatically gets extended from three years to seven. They call it a merit award or something like that. And that reduced the burden on the really good investigators dramatically because they weren't rewriting the grants, which takes a tremendous amount of time, and all the rest of the rigmarole.

It didn't change the budget, per se, it just reduced the burden and let those people, who everybody knew should get funded anyway, get funded without going through all the stuff.

We want the kind of a model relevant to that. We want to try to identify the regulatory burdens that are on the providers in the usual and customary way and then find some criteria where we would waive those or do it every four years instead of every two years, or whatever it is. Something like that for those providers. That would be, I think, a direction to go in.

MR. HACKBARTH: Let's do a straw vote. How many people would support a recommendation that's recast in that direction? The question is, Floyd, a substitute for this, a recommendation that says providers that have been in the program and have sustained good performance ought to be

subject to less scrutiny than others.

DR. ROWE: Sort of like the merit awards your wife invented when she ran NIH. That's the idea.

DR. REISCHAUER: One question is, what is good performance, and how do we measure it? And how much of a burden is it collecting the information to show that you're a good performer. And if I'm not correct, I remember that a surprising number of academic medical centers were sort of caught up engaging in behavior that was against Medicare rules.

MR. HACKBARTH: So we'll say explore, Bob.

David, could you come back with something along those lines?

MS. BURKE: Glenn, I also wonder, following on Bob's point of not being sure how we measure it, query with respect to individual physicians. What is the regulatory burden we are going to propose to relieve them of? What is the routine, because there isn't any?

I mean, I agree with moving in this direction but I think the question will arise, having said that, what is it we're going to relieve them of? And I don't know that I know --

DR. NEWHOUSE: Do we do any sampling for auditing purposes, ala the IRS? That would be a logical way to do this.

MR. GLASS: Random medical review.

DR. NEWHOUSE: So just different sampling probabilities then.

DR. ROWE: They may have to submit quality data or whatever it is they have to do. They're always complaining that they have to do so much for Medicare, so let's find out what they have to do.

MR. MULLER: An analog to your NIH example is you could do the Joint Commission every four years versus every three.

MS. BURKE: So the question is, what is it for docs? For institutional providers it's not a challenge. We know we can get there. But the question is for the docs.

MR. HACKBARTH: So include in the text, you're suggesting, some example of how this might apply to physicians.

Number five?

DR. NEWHOUSE: Doesn't this require some statutory change?

MR. HACKBARTH: David reported that he thought that it did not require statutory change, if I understood him correctly.

MS. LOWE: Currently, the Secretary of HHS and the Secretary of DOJ have issued some joint guidance on coordinating their health care fraud and abuse investigations. In looking at that guidance, it looks like it might be a target for improving how they do that coordination, which would not require new legislative authority to do that. It would just be changing their operations.

MR. HACKBARTH: Any other comments or questions on this one? So the vote is on recommendation five. All opposed?

All in favor?

Abstain?

Number six. Any discussion?

MS. NEWPORT: I brought this up last meeting and I think -- Carol's left -- she questioned me on it. In testing, a lot of people would see them as just testing the payment methodology, what's in the systems infrastructure, so that A plus B equals C except when it doesn't. You can

see how it's worked for our plan.

But at any rate, I think it's important to make the distinction here, too, that appropriate notice of proposed rulemaking with time sufficient enough to have people put in their comments and take a look at the regulations is really important. And we do capture that. Part of it will be a challenge as to whether or not Congress accepts our suggestion that they provide reasonable timelines.

Because there is some benefit to having a time definite by which these things are put into place, particularly when we all want more money for something. We wouldn't want that to work against us.

I just think that the issue comes down to is the ability for appropriate operational concerns, whether it be doing HIPAA implementation sequentially and having to have it in place before all the regs are out, or when you're talking about a profound change in what you're doing and an amazing underestimation of what it's going to cost. 100 man-hours, I think, was in the regs for HIPAA. We exhausted that just reading half the regs that were out.

So I think what we're trying to achieve here is a

balance and I think that we need to acknowledge some of that. But the testing is absolutely valid when it comes to changes in formula and I think it's also valid in terms of explaining the right way that an appropriately vetted process by which regulatory changes and regulations that are promulgated, understanding the real impact and the magnitude of change that might be imposed that isn't necessary or isn't necessarily good for beneficiaries is important.

I know you're happy to know, this is what I forgot earlier. I'm not quite sure what I'd suggest in terms of change to this, and I don't have any problem with the recommendation at all, but I think we need to understand that we're talking about a more thoughtful process. The testing just isn't systems testing. There's a vetting process.

And I think you get there in your text, but --

MR. GLASS: We tried to put that in the text. I'm not sure how you want to change the recommendation.

MS. NEWPORT: It may not need to be changed. I'm just concerned that there are a lot of things that go on that can't be reduced to a formula.

DR. STOWERS: I just scribbled in after test

regulations because I agree that there are regulations that you'd hate to have delayed by this, just something like after regulations that increase regulatory burden and complexity thoroughly before implementation. So it should limit it to those that might do what we're talking about, and that's bring about extra financial burden or complexity or whatever, that those be tested.

Because this kind of seems like every single regulation that comes out is going to have to go through some testing process, and it might be good to clarify that we mean those that add to the burden or complexity. But maybe that's overstating it.

DR. NEWHOUSE: We have the weasel word in the text of when appropriate, but we don't really say very much about what we might mean by that. I think we should proceed, because we're already so past our schedule.

MR. HACKBARTH: Let's do a straw vote on Ray's recommended addition that clarifies that we say adopting.

DR. ROSS: If I could have one clarification. As the recommendation is drafted it's a recommendation to the Congress to give reasonable timelines, which presumably still leaves CMS to use its judgment as to whether

regulations need to be tested. I would actually argue for leaving it as it is.

DR. STOWERS: I think we ought to say that in the text, though.

MR. HACKBARTH: A vote on recommendation number six. All opposed?

All in favor?

Abstain?

Number seven? Any comments on number seven?

DR. REISCHAUER: I'm against it. I think we should keep all of the old ones in place for historic purposes.

[Laughter.]

DR. ROWE: I think the record should say something like consistent with his long-term performance, Reischauer voted against this regulation.

MR. HACKBARTH: When we joke about, how can anybody oppose this, that's a sure sign that it shouldn't be included as a recommendation. Seriously, it's just not saying anything. It's gratuitous. So I would be inclined to not --

DR. REISCHAUER: Unfortunately, it's not. It

seems like common sense, and yet these things are still around.

DR. ROWE: Leave it in.

MR. HACKBARTH: The vote is on number seven. All opposed?

All in favor?

Abstain?

Number eight? Any comment on this?

DR. NEWHOUSE: And appropriate the resources required for CMS to proceed.

MR. HACKBARTH: Appropriate or provide?

DR. NEWHOUSE: Provide is better.

MR. HACKBARTH: That's fine.

DR. STOWERS: I was just going to say, one thing that kind of hit me was it's just to pursue new technology. What we were talking about before is going to be a lot more than technology. It's going to be a lot of rearrangement of structure and so forth if we go through what we're going. So I didn't know if we wanted to just limit it to technology, but that's fine if we do.

DR. LOOP: It's also resources to provide more current data. It's an IT resource investment.

MS. BURKE: Why not say new technology and resources that are necessary?

MR. MULLER: Or just strike after resources.

MR. HACKBARTH: What I hear Floyd suggesting is that it's even beyond simplification. It's, in some cases, to produce a new product like more timely information for policymaking that may help us do things better for providers.

DR. LOOP: A lot of administrative improvement is based on having current data. That's all I was saying.

MR. GLASS: We were focusing on the technology aspect here because we had already covered resources for other things earlier. Here we're trying to focus on the technology aspect. The common working file is an example, I think, of what Floyd's talking about. You need to be able to know if someone's enrolled or not. That would be nice.

MR. HACKBARTH: Unless there's a strong objection why don't we go with this language. We can fiddle with whether it's provide or appropriate, but the substance is this. All opposed to number eight?

All in favor?

Abstain?

DR. BRAUN: I hate at this moment to bring anything else up, but I just wonder, I know we to take up in the text somewhat, but I'm concerned about unintended consequences that could come out of these changes. I don't know whether we need a recommendation as they begin to take the specific steps to reduce this complexity and regulatory burden, I think they need to be very careful to look to see what these changes may bring about in unintended consequences, consequences that could affect the program integrity efforts, the quality standards, and a lot of beneficiary protections.

I don't know if we need that in another recommendation. I just think it needs to be brought up.

MR. HACKBARTH: I would suggest that we not do it in a recommendation. This takes me back to a comment that Alice made earlier about the complexity of the contractor changes. I think it would be good to have some very clear language early on that says we recognize that some of these involve a very significant change of direction for the program and will be complex to do and may lead to some surprises and we realize that.

We're pointing in a direction, though, that we

think is very important for the program and worthy of the significant investment of effort.

DR. ROSS: If I could add a further point on that. One of the things that was brought up at the beginning of the report is this distinction between reducible and irreducible complexity and that many of the consumer protections and other things that you would worry about have at least analytically been walled off as being essential in trying to get at the things where -- what's your analogy, David -- we can prune some low-hanging branches.

MS. ROSENBLATT: Glenn, I'm sorry, just one add-on since you just quoted me. In addition to it being very difficult, also anything involve the kind of technology we're talking about is extremely expensive. So if, along with our narrative, we mention that. We're interested in getting to efficiency in the long-term, but I think care needs to be exercised.

I don't think we'd want, in voting for this last recommendation, that we'd given a blank check to pursue all sorts of technology. I think we need to be careful.

MR. HACKBARTH: Public comment? And since we're already well behind schedule I'd ask the commenters to keep

their comments brief and to the point.

MR. CONNOLLY: Members of the Commission, my name is Jerry Connolly. I'm with the American Academy of Family Physicians. I'd like to just comment briefly on the last issues that you were dealing with relative to Medicare complexity and the regulatory burden.

Specifically, I know you spent a good deal of time on recommendation number two, but I would like to echo some support for that. In fact, a good deal of support for that notion of including the issue Dr. Nelson was talking about relative to asking the provider for refunds when and if the provider has actually issued these services or provided these services after receiving written approval and concurrence from the contractor or from the program.

It is difficult to obtain guidance. There's no question about that. We would agree that if the guidance is verbal, it is vague. And if the guidance is obtained, however, prior to delivering services and services are delivered on the basis of written guidance, budgets are administered and developed, those kinds of things should not be penalizing the provider for issuing and delivering the services to the patient who, in the provider's judgment,

needed those services.

If, in fact, someone is going to be held accountable for spending that money, it should not be the provider who delivered the services to the patient who was in need, but it should be the contractor who erroneously delivered that written information. So the written information should be what is adhered to.

Secondly, you had talked about the Medicare Coverage Advisory Committee process being a nationwide process that determines what kinds of services are allowed and what kinds of services are covered. It is, in fact, in existence. It's a nationwide process for national coverage decisions. However, it's a fairly new process. It's only about two years ago.

There were some bumps in the process early on, as I think you know, but it's working more smoothly now. It's a long, complex and arduous process. It takes, in some cases, a year, a year-and-a-half, even two years to get a final decision from the Medicare program relative to the coverage issue that goes before it.

It goes before a Medicare Coverage Advisory Committee. It goes then to the executive committee. It

then goes to staff and then it goes to a final decision that is written and disseminated.

These decisions are based on answering the question of is the scientific evidence adequate to determine efficacy for this particular service. Now some will argue that that bar is too vague because that is adequate? The definition of adequate has not been delineated. Some will argue that the bar is too high.

Inherently, we would say that this is not a bad idea, to determine whether or not something is efficacious before coverage is determined or a coverage decision is made. However, if you're thinking of moving all of these issues that are determined at the carrier level now, and there are a number of issues that are at carrier discretion now, and moving them through a national process, moving them through the Medicare Coverage Advisory Committee process and depending upon that process to make those judgments, I think will overburden the CMS and overburden this MCAC process.

So we would leave you with those particular thoughts relative to the recommendation number two, and it really is an issue of supporting that, but with those caveats and those comments. Thank you.

MR. HACKBARTH: Thank you.

MS. MEANS: I thought this was going to be a good morning, Glenn, congratulations on your new position. But I see it's good afternoon on this subject. I'm Kathy Means with Patton Boggs public policy practice. I just wanted to offer a couple of comments, not from a client perspective but from a background on having worked on both the contractor reform and some of the regulatory issues you've debated this morning.

It seemed to me one of the problems that you're dealing with is drawing a distinction between contractor reform and then regulatory reform, and I think they're actually quite separable issues.

On the contractor reform, the objectives that we were talking about in the past were really competitive procurement, allowing a diverse array of firms to compete for these intermediary contracts, systems streamlining -- although I hope your chapter recognizes, or at least diagnosis, some of the failures under the Medicare transaction system and what the implications of that are for your recommendations. And finally, to eliminate the provider election of intermediaries and carriers.

One of the major objectives of contractor reform, and I would be disappointed if MedPAC didn't speak to this, really are performance standards and the performance requirements that the contractors live under from the agency. Because that directly, in many areas, relates to how they interact with the provider community. And I think there are several instances where you've discussed things this morning where a connection could be drawn between the performance requirement that's imposed on the intermediary or carrier and the implications of that, in turn, for regulatory burden or administrative burdens on the industry.

Secondly, and this is from my former experience years back previously at HCFA as director of executive operations where I oversaw the regulatory process. Back in the early '90s, at that point in time, at any given point there were about 200 regulation packages in progress. I just wanted to mention that has only increased in terms of the annual work underway in the agency.

They do actually have a systematic process. They may not be executing it very well, but they do have a process for determining that certain roles are obsolescent. And that should be part and parcel of any regulatory notice

establishing a new role. Once you go to a final rule, you should be recodifying and identifying obsolete rules as part of that notice.

The larger program is actually program memoranda and other kinds of instructions which number in the thousands and which they have much more difficulty and much slower execution on eliminating those older program memoranda and eliminating them.

The last comment I'd make, and this is client related and I am working with some technology companies on their coverage concerns. I would just mention that some of us participated in a seminar last week that CMS and some of the companies did with the National Health Policy Forum on the Medicare coverage process. Sean Tunis at CMS acknowledged that they do not have the capacity to centralize local coverage determinations any time in the foreseeable future.

Less than 10 percent of the coverage decisions made annually are national. They also acknowledge that they need considerably more resources. They would need to have considerably different composition of staff, and this goes to the last comment on your final recommendation. It is

more than technology. There are changes that the agency needs to make to restructure and they need to change the composition of the people they have and the credentials of those people.

I would point out that, getting to the issue that Bea identified earlier with the shoe, the concern that I hear from the company standpoint is whether or not they will retain the ability in the future to do this very personal low scale and what is essentially development of a new device -- and it's not all devices, it's also actual physician practice. Particular medical procedures get tested.

There are communities, like Boston for instance, where there's a high concentration of highly skilled professionals. The companies tend to work with some of the teaching hospitals. They work with very specific physicians to test and develop a particular product. They will work with a local carrier medical director in order to advance that and deal with the coverage during the clinical trial process in some instances.

And once those early decisions are made, then diffusion occurs over time throughout the program. Those

preliminary decisions are made based on the work of what can be a very small set of scientists. Information is gradually diffused throughout the Medicare system. And it does lead, sometimes, to disjunctions on individual coverage. But those tend to be more the exception than the rule, at least as far as I've seen.

Anyway, I compliment MedPAC. I've always been a champion of the organization. Thank you.

MR. HACKBARTH: Okay, we're going to adjourn for a half an hour for lunch. So we'll reconvene at 2:00.

[Whereupon, at 1:29 p.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION [2:12 p.m.]

MR. HACKBARTH: The next item on our agenda is payment for outpatient pain management procedures. Nancy and Kevin.

MS. RAY: Good afternoon. This study is in response to a Congressional mandate in BIPA that MedPAC examine whether Medicare imposed barriers on the provision of interventional pain management procedures in physicians, offices, hospital outpatient departments, and ambulatory surgery centers. In the statute, the Congress explicitly asked us to examine whether there was variation in payment across these ambulatory settings.

This study is due in December. We are looking for the Commission to comment on our draft letter to the Congress on our five draft recommendations.

To help inform the Commission on this topic, we contracted with Project HOPE to review the literature, to look at Medicare's coverage and payment policies concerning interventional pain services, and to interview interested parties. A draft report from Project HOPE was included in your mailing materials. This is the same draft report you saw last time. They are still in the process of making

changes to it. You will see it in its final form and then you will, of course, have opportunities to comment on that.

In your mailing materials, in our response to the Congress we included an appendix what are interventional pain procedures. We define them as minimally invasive procedures such as injection of drugs in targeted areas, ablation of targeted nerves, and certain surgical techniques that includes diskectomy, implanting, infusion pumps and spinal cord stimulators.

This recommendation, draft recommendation one, addresses the issue that we did find large differences in the payment rates for many types of services, including interventional pain services across ambulatory settings. Payment in ASCs are generally higher than those in other settings while physician practice expenses are lower.

Some of this variation may reflect differences in the underlying cost structures across these different ambulatory settings. In addition, some of this variation may also reflect the different basis for payment across these settings.

The concern here, however, is that such variations in payment could lead to shifting of care to inappropriate

settings. If care is shifted among settings, it should occur for clinical reasons and not because of payment reasons.

So draft recommendation one actually reiterates a MedPAC recommendation that we made back in March of 1999, saying that the Secretary should evaluate payments for services provided in hospital outpatient departments, ASCs, and physicians' offices to ensure that financial incentives do not inappropriately affect decisions regarding where car is provided.

Onto draft recommendation two. This recommendation addresses the issue that ASC payment policies are somewhat dated and this may be contributing to the inconsistency in payment across ambulatory settings. ASC payment rates are probably not consistent with their costs because the rates are based on old charge and cost data from the late 1980s. CMS is statutorily required to conduct a new rate survey every five years.

Another concern that we noted in our letter is that the list of procedures that are paid for when performed in ASCs has not been updated since 1998. Again, the concern is new procedures come out, new medical advances come out.

CMS is not updating the list. CMS is statutorily required to review the list at least every two years. So draft recommendation two addresses these issues by recommending that the Secretary should evaluate rate for ASCs using recent charge and cost data, and that he should also update the list of procedures that are covered when performed in ASCs.

Draft recommendation three. This recommendation addresses the issue concerning the adequacy of the practice expense allocation for physicians that are performing interventional pain procedures. Our analysis found that, in general, the practice expense payments are lower compared with the facility payments to hospital outpatient departments and ASCs. We do not know if payments are adequate or not adequate because data on the costs of providing these procedures in office settings is lacking.

Of concern, however, is that beneficiaries' access to high quality care in office settings could be adversely affected if payment amounts are not adequate.

Physician practice allocation is a function of the practice expense of the physician specialties who perform a particular service and the mix of physician specialties who

perform these services. With respect to interventional pain procedures, from the best that we can tell, a wide variety of physician specialties perform these services, including anesthesiologists, neurologists, physicians specializing in physical medicine.

The practice expense per hour data that is from the AMA survey for those specialties varies -- there's great variation, anywhere from about $27 for anesthesiologists to $88 for physicians specializing in physical medicine.

CMS will begin to recognize pain management as a specialty in January 2002. At issue is whether this new specialty will affect the adequacy of the practice expense allocation for interventional pain services. We have no way to ascertain how this new specialty designation will affect payment adequacy until data becomes available on the practice expenses of the physicians who will come forward and identify themselves under this new specialty designation and two, the mix of physician specialties who will ultimately perform these services.

This led us to draft recommendation three, that the Secretary should recalculate the practice expense payments for interventional pain procedures when data become

available on the practice expenses of physicians specializing in pain management.

Now we note in our response that if it appears that the practice expense allocation is not affected by this new specialty designation then the agency should consider other means to address this issue that potentially the practice expense allocation may not be adequate.

Onto draft recommendation four. This recommendation addresses our finding that inconsistencies in coverage policies occur across localities. Again, we've already spoken a lot about this issue in David's session on regulatory complexity, but there are many Medicare contractors who implement local coverage policies, the FIs, the carriers, and the DMERCs. They each can set policies within a given specified geographic area.

I did note in our response to the Congress that the variation in local coverage policies does exist despite efforts by CMS that requires its contractors to develop LMRPs that are evidence based, to establish an open and public process for developing LMRPs and to share information among one another.

MedPAC's and Project Hope's review of the medical

literature suggest that there are limited number of randomized control studies evaluating interventional pain procedures. This may be hindering the ability of Medicare's contractors to establish policies in this clinical area.

Why we're concerned about this is this disparity in local coverage decisions is affecting access to certain interventional pain procedures. For example, several characters have issued different LMRPs about the number of facet joint blocks that can be provided during an encounter and the indication for which this procedure may be performed. This led us to draft recommendation four, which recommends that the Secretary sponsor additional research about the effectiveness of these services to strengthen the evidence bases for Medicare's coverage decisions.

We talked about two ways in the response to the Congress about how the Secretary could do that, including using provisional coverage as one way to further research. In doing so, they would be able to collect outcomes data and make a better informed evidence based decision about these services.

The other vehicle that we also include in our response is that the Secretary could pursue clinical

research with NIH. Right now NIH and CMS are trying to get a daily dialysis clinical trial off the ground. We cited that as an example.

The last recommendation, recommendation five, reiterates our recommendation that we have made in the regulatory complexity analysis. That is ultimately the Commission believes that CMS should move to a standard nationwide system of claims processing, which would basically eliminate LMRPs and require that nationwide decisions be made about the coverage of medical services.

This recommendation, however, I don't think diminishes the need for the fourth recommendation because we still need additional information about the effectiveness of interventional pain services in order for whoever is going to be making these decisions to make evidence based decisions.

That's it.

DR. LOOP: I thought this was well done. I've got a couple of editorial points. On page two, the two bullets, the first and third bullet could probably be combined. You don't need to comment on that now, but just think about it.

There's also, in the second bullet on page two,

you comment that the delay in variation payment may adversely affect beneficiary access to care. I don't think there's any evidence of that. If there is, tell me. But before you answer it, let me tell you one other thing that relates to access to care.

On page four, at the bottom of four, you said despite variation in payment across ambulatory settings you didn't find access had been compromised. And then in the middle of page four you said Medicare policies for ASCs may be adversely affecting beneficiary access.

MS. RAY: You're right. We will go back and try to be consistent about that. You were right, we found hard evidence that access is, in any way, being compromised.

DR. LOOP: I would eliminate recommendation five, since we already addressed it.

DR. NEWHOUSE: This is not exactly the question the Congress asked, but it's related and I'd like anybody's view, particularly Carol's.

In this little study we did of hospice, which we referred to in the hospice, we found anecdotal reports when we went out in the field that access to the high end pain meds was a problem given hospice reimbursement. That is

what we talk about payment variation across ambulatory sites. And since a lot of it is in the home, that's an ambulatory site.

I'm just wondering if we should have a recommendation that the Secretary should investigate whether there are problems on the hospice front.

DR. ROWE: Let me comment on that. I think at least one study I'm aware of demonstrated that in areas which were disadvantaged, particularly urban disadvantaged areas, there was very limited access to pain medication for individuals who really needed it. And it was because, in part at least, the pharmacies were not stocking substantial amounts of these medications because they were afraid of theft and getting broken into, et cetera, et cetera.

So in fact, in one study in New York that I'm aware of, that was a significant problem.

DR. NEWHOUSE: Of course, it will only be part of Medicare through hospice.

DR. ROWE: It probably wouldn't be through hospice unless the hospices were located in certain areas.

DR. NEWHOUSE: I mean it's not covered otherwise.

DR. ROWE: Oh, it's not covered. But the pain

medicines that we're talking about here are injectables which are given by physicians in their office or in a facility, not something -- so these would be covered, is my point. They're not something that would be in a pharmacy.

DR. NEWHOUSE: But on the hospice side they are covered.

DR. ROWE: With respect to this, I thought this was interesting and well done. I'll reiterate the comment I made last month. I'm surprised there's not an access problem. I'm delighted but I'm surprised because I see this as a very heterogeneous specialty that's just developing. And some cities have really good pain clinics, some hospitals have really good pain programs. Others you can't seem to find one.

So I'm surprised but I'm just wondering whether that means that we're lumping different kinds of pain treatment capacities together when they really aren't as robust as they might seem from these data. That's just my personal experience, but it's an anecdote. Floyd's laughing, he probably has the same anecdote, but the plural of anecdote is not data, so we're not going to go there.

The other thing I would say is it says here that

Medicare is going to recognize this as a specialty soon and then it talks about the 3,000 anesthesiologists that have some sort of certificate of added qualification after their board certification.

I just want to make sure that there are other physicians besides anesthesiologists, neurologists, physiatrists and many others, neurosurgeons, orthopedics I can imagine, who perform this kind of a very important and valuable service to Medicare beneficiaries on a regular basis. And so I want to make sure we don't get into some compensation system where some groups of physicians are disadvantaged because they don't have some credential but they would be perfectly able and capable of providing this service in their office and should get compensated for it.

It doesn't say that here, but I just want to make sure that that's not the intent.

MS. RAY: That was not the intent. I just put that in as an example to show that the anesthesiologists did certify pain management as a subspecialty. It's my understanding that when a physician comes forward and identifies himself under a specialty that -- you know, a neurologist could come and identify himself as a pain

management specialist. He does not have to be certified by any one group.

MS. RAPHAEL: Just a clarifying point. I agree with what Joe has said, because within hospice one of the most serious issues is how to manage the cost of pharmaceuticals. It does become an issue of access because hospice will screen out those with high costs, because they know that it's going to be very difficult to incur that level of expense.

I think that's a separate issue from what Jack is raising, which is in some inner-city communities pharmacies will not store narcotics and pain meds, and therefore patients in those communities don't have access to those medications. They're two separate issues.

MR. DEBUSK: This is a question, and I was reading over the information. On page six it says for example, under the DME fee schedule, ambulatory pain pumps are reimbursed between $6,400 and $7,500 where the ASC payment for this product is $433. Are you sure that $6,400 and $7,500 is right?

MS. RAY: In the case of the ASC payment, they don't receive separate payment for the pump. I will go back

and double-check my numbers. That is what our contractor gave us and she was very confident about those numbers, yes.

MR. DEBUSK: I have a hard time believing a cost to a hospital of a $200 pain pump would sell for $6,400 or $7,500. I'd like to sell those pumps.

DR. HAYES: I just have one clarifying question about Joe's thought regarding hospice, and that would be whether you would anticipate putting a mention of hospice in draft recommendation one? Would that work in this case?

The other think I would point out is that you do, of course, have another opportunity to deal with hospice issues and cost to the high end drugs that you referred to as part of the study that we'll be talking about tomorrow.

DR. NEWHOUSE: I wasn't opposed to dealing with them in both places. As for one, I guess my off the top of the head reaction is that this seems to be focused on site of care as opposed to provision at all. I would have kept it separate, but if we're going to include it -- I mean, one possibility is to say they didn't ask us about hospice here so we shouldn't have it in.

MR. HACKBARTH: Any other questions or comments? Let me ask a question about the first recommendation.

We've got big variations in the amounts that are paid for outpatient departments, ASCs, et cetera. The decisionmaker, though, about the location of the service, I would assume is usually the physician. The amount that's paid for the facility expense may or may not affect the decision that the physician makes about the appropriate location, right?

The text, at least when I read it, it sounded like there's this direct connection, if there's a difference in the facility expense and you pay more in one location than another, that all the business is going to flow that way. But to the extent that the physician is the decisionmaker, that doesn't necessarily follow, right?

DR. HAYES: The one situation I can think of where it would be a problem would be if there were let's say errors in our payments for services when they're offered in a physician's office. In which case, then the decision well may be a different setting.

MR. HACKBARTH: Clearly that's the part that's sensitive. If you're not paying the physician's costs for the facility, the office component, then obviously you're going to drive the care elsewhere.

DR. NEWHOUSE: Plus the text here talks about the ASC itself becoming the DME supplier. And since the physician would normally be an equity owner in the ASC, it does come back to the physician.

MR. HACKBARTH: My thought was just that the discussion in the text maybe doesn't capture all of the complexity of that decisionmaking process about the location of care.

DR. HAYES: If I may, we recognize that this is a very complex problem, and that's part of the reason why this is a the secretary should evaluate type of thing. We're just trying to lay the groundwork for that kind of evaluation.

DR. NELSON: Following up on Glenn, help me understand the variability in the patient's out-of-pocket costs depending on the setting.

DR. HAYES: In the case of physician services and services provided in physicians' offices and in the case of services provided in ASCs, the coinsurance rate is 20 percent. In the case of hospital outpatient departments, the situation is much more complex. We're going through a lengthy process of the so-called buydown of beneficiary

coinsurance in the hospital outpatient department. And so I guess it's fair to say that typically the copays in the outpatient department would be higher.

DR. NELSON: You may have had it here in the report, Kevin, and I've forgotten, but do you say anything or know anything about the relatively proportions of services provided? Whether most of them are provided in one or the other kind of setting? I'm trying to measure the burden on the beneficiary with this question?

DR. HAYES: We have that information and it's not in the report. Is in the contractor's report?

MS. RAY: It may be in the contractor's report. But we have that information available and we can address that issue.

DR. NELSON: I think it would be useful.

MR. HACKBARTH: Any others? Are we ready to vote?

DR. NEWHOUSE: What do you want to do with the hospice?

MR. HACKBARTH: Read what you have --

DR. NEWHOUSE: I was winging the wording, but it was something like the Secretary should investigate whether reimbursement for pain medication and hospice benefit is

adequate.

DR. ROSS: Given that we already have something going on hospice, which we'll start with first thing tomorrow morning, my preference but I can't argue too strongly would be to deal with it in that setting.

DR. NEWHOUSE: I think we could there, too. There's just six months difference in when these two reports get delivered, which seems to me to be -- I don't want to push too hard.

DR. ROSS: Given the lag between recommendation and congressional action, I wouldn't worry too much about that.

DR. NEWHOUSE: In the first instance, I don't think you need Congressional action. I think you need CMS to do some investigation of what's going on.

DR. HAYES: It's not my place, Joe, to argue against doing this, but remember that in this case we are talking about a very specific group of pain management services. Those would be the interventional ones, the ones that involve, in general, threading of some kind of catheter and placement.

Now that's not to say that interventional pain

management services are not provided in hospices or that they couldn't be. The one example that we've been provided with has to do with implantation of these intrathecal pumps. Just bear in mind that it's a different kind of issue than the general matter of pain medications in hospices, which are probably an important thing.

Sally points out that the other factor involved here in any kind of an assessment of payment adequacy for medications in a hospice would probably be dependant on the availability of cost report data which are coming in now, which are being assessed and so on. So I think that there's some lag built in. That's something we're confronting regardless, which may argue for Murray's comment about --

MR. HACKBARTH: Joe, given his points, I would prefer that we take it up in the context of the hospice report. Is that okay with you?

Okay, recommendation number one. All those against?

All in favor?

Abstain?

Recommendation number two. Voting no?

In favor?

Abstain?

DR. REISCHAUER: I was just holding up my hand about the use of the word "he" referring to the Secretary.

DR. ROSS: Have you met him?

DR. REISCHAUER: I'm just generally in favor of not its.

MR. HACKBARTH: Draft recommendation three. Voting no?

In favor?

Abstain?

And draft recommendation four. Voting no?

In favor?

Abstain?

Draft recommendation number five. Voting no?

In favor?

DR. ROSS: We're pending this one.

DR. LOOP: I thought we did this?

MR. HACKBARTH: We did. The only question is whether it bears reiteration in this context. And Dr. Ross, you were about to say?

DR. ROSS: I'll let you make the decision. Generally making recommendations twice I don't find

particularly helpful.

MR. HACKBARTH: I would say let's not do it. If we need to make a cross-reference in the text to our recommendation, that's fine. Okay.

Thank you very much, Nancy, Kevin.

Next up is blood safety requirements. Tim?

MR. GREENE: Good afternoon. I will be discussing the revised BIPA mandated report on the treatment of blood costs under the inpatient PPS, as well as the recommendation that you discussed last month.

As we noted then, hospital blood-related costs have increased more rapidly than overall operating costs. The hospital marketbasket, which largely determines PPS updates may not appropriately reflect changes in the price of blood products. This may lead to inappropriately low updates in coming years if blood-related costs associated with new technologies increase.

BIPA required MedPAC to conduct a study on increased costs associated with blood safety requirements and new technologies required to meet them. It also require that you consider changes to the inpatient PPS to adjust future cost increases.

Last month I presented an overview of the draft report to Congress. Your briefing material includes a revised version of this report. We made changes to reflect the discussion last month, to incorporate the results of new analyses, and to include the text of the recommendation that you discussed. We will incorporate your comments today when we revise the report. We will not take it up again. However, we will send you a copy of the final report as revised before it's submitted to Congress on December 21st.

This is a review of where we were last month. As we discussed then, we examined growth in total hospital blood-related costs per discharge for all PPS cases and for discharges for beneficiaries who use blood alone. In both cases, blood-related costs grew somewhat faster than overall hospital operating costs.

The results you see in table three of the revised report in your briefing material update the results you saw last month. We used a larger sample of 1986 cases to develop these numbers, a 20 percent sample of patient stays rather than a 5 percent sample, and got somewhat different results. In particular, we got slightly lower growth rates in blood costs per discharge and overall costs per

discharge. But exactly the same differential between growth rate for blood costs and growth rate for other.

So the results, in that regard, are the same as the ones you saw last month. Blood-related costs per discharge grow at 0.6 of a percentage point more than overall costs. As with last month, we found very little impact of blood cost growth on overall hospital costs.

We can update some information we presented last month that got people's attention, I think. At that point we informed you of a July 1st Red Cross blood product price increase that we were citing as a 35 percent increase. We looked into it further and found that Red Cross had announced a 10 percent to 35 percent range of price increases to different hospitals at different points in their contract cycle, and so on.

An AHA survey of some of its members found a 26 percent -- not a 35 percent, a 26 percent -- increase in the price of blood purchased from Red Cross and a 12 percent increase in price from independent blood banks. That translates into an overall 21 percent price increase of blood from 2000 to 2001. You should think of that, rather than the much higher 35 percent number we quoted last time.

We showed you these options at the October meeting. You gave preliminary approval to the first, the marketbasket option, but did not adopt any of the other three. I will summarize them briefly at this time and give some information on them.

In the second option, blood safety costs would be treated as costs of technological change. However, your new update framework does not include costs for technological change or other add-ons except in exceptional cases. Blood safety technologies which affect a very small share of overall hospital costs may not qualify as exceptional cases for this purpose.

In the third option, a fixed add-on would be included in the update explicitly identified as blood-related cost adjustment. As we noted last time, this could be an unfortunate precedent that could lead other interested parties to come in with requests for similar add-ons for other products or costs. And in any case, the Congress considered and chose not to follow this route when it adopted BIPA last year.

Finally, blood costs could be addressed using the BIPA new technology pass-through provisions. However, these

provisions were designed for technologies used by hospitals in the inpatient setting. They probably are not applicable to blood safety technologies used by blood banks that supply products to hospitals. Changes in costs such as those should be addressed through marketbasket adjustments for price changes.

In general, any interim adjustment to 2002 rates would entail a revision in the recommendation you made in your March report. In that recommendation you indicated that the update scheduled in law was appropriate and adequate to hospitals for fiscal year 2002. You may not want to modify that at this time and you certainly may not want to for as small a change as would probably be indicated for this case.

This is the draft language of the recommendation you discussed at the last meeting. It indicates the two alternatives are mutually exclusive and that we would expect CMS to consider both and choose between them. The alternatives basically are that CMS could reintroduce a separate cost component for blood in the hospital marketbasket, possibly using the producer price index for blood and derivatives as price proxy. This would be a

return to a marketbasket design used before fiscal year 1997.

Alternatively, CMS could create a new marketbasket category for blood-related costs and other related costs. It would then identify an appropriate price index to use as proxy. We present a specific example in the report which uses PPI for biologicals products as a possible proxy for a not completely specified cost category, as we discuss it in the report.

I should note that when CMS next revises the hospital marketbasket, which we expect to occur next year in preparation for the fiscal year 2003 rates, BIPA requires it to give special attention to the adequacy of payment for blood and blood products. These alternatives that we're discussing here are, we think, consistent with what BIPA requires. They would allow the marketbasket to better reflect changes in the prices of blood and blood products as new technologies are adopted during the next decade.

I'll take any questions at this point.

MR. HACKBARTH: Tim, help me understand how this would be reflected in the BLS statistics. I'm going to reveal my ignorance here -- but they're measuring price

changes for -- at least theoretically -- constant products. To the extent that this is viewed as a different product, will this be picked up in their measures?

MR. GREENE: We think not. They do make quality and products change adjustments periodically. They tend to focus sophisticated analysis on things like computers and autos and other major products where they can get a reasonable measure of change and costs associated with change.

We understand, from speaking to BLS, that they wouldn't expect to make such quality change adjustments in the blood and related areas.

DR. NEWHOUSE: But they have discretion about whether they want to treat it as a new product. They can just ignore it and say the price went up 20 percent.

DR. ROWE: I think that there are two pieces here. One is that there are different products like a blood product that has been cleansed of its leukocytes or something like that. You could label it as a different product. But the other piece of this is that some of these emerging technologies, which are very expensive and will be very widely used, like viral inactivation, probably are not

going to qualify as a separate product. It's a way that the given blood product or these packed red blood cells, whole blood, leuko-reduced blood or what it is, is treated. Everything is going to get this treatment. It's very expensive and it's kind of a technological advance rather than a new product.

I don't know whether the BLS or whatever it is, the mechanism would capture that or not. But I think there are two different things here.

MR. GREENE: That's true.

MR. HACKBARTH: My concern would be that we would say, this is not a change in the hospital product. That's why we don't think it's appropriate for the technology adjustment. This is a change in input. And so we say we ought to have a good measure of input price changes, a better one than we've got now. And that will capture this increased cost to hospitals. And that's how it ought to flow through the Medicare payment system.

If, on the other hand, then BLS says well, this is a product change and we're just going to measure the price change for old fashioned blood, then there's a catch-22.

DR. ROWE: They're not capturing the real change.

Why is it not an S&TA change? Because it's not something that's occurring in the hospital?

MR. HACKBARTH: THE hospital is not producing it. It's the change in an input that the hospital is using.

DR. ROSS: Just to clarify, it's because of the approach that we've been discussing, and will be discussing more this afternoon. The S&TA is built in. It's not that we're not accounting for it. It's that we're not identifying every individual component separately.

DR. ROWE: I understand that. I'm just remembering -- it's been a year, but remembering how hospitals run, we don't get all of our blood from the Red Cross. People go to the hospital and donate blood. They donate their own blood. They donate blood for their friends. That blood gets used in the hospital. Somebody is paying the salaries of people. It gets leuko-reduced in the hospital, I bet. It gets virally inactivated in the -- I mean, it's not all bought on the market. And so there is a -- my guess would be that some hospitals buy more than other hospitals. But I'm just not sure it's purely -- I don't know how to handle it.

DR. ROSS: Jack, that again is one of the reasons

why you don't unbundle all the individual components.

MR. GREENE: Just for your information, Jack, it is done by hospitals but 7 percent of the country's blood is collected by hospitals. The rest is purchased. The vast amount of blood is bought from the market.

MR. HACKBARTH: Given that, it would be captured through an input price measure change, if in fact, this sort of change is captured by the BLS measures. That's my question.

DR. NEWHOUSE: This was sufficiently small scale that I wasn't concerned, but it seems to me, given your concern, you would want to know how BLS was, in fact, treating this. And that should be known because these are products that are on the market. The BLS can be asked what they're -- this just is coming in as they're ignoring the change in product for the purpose of the PPI.

MR. GREENE: My discussions with the BLS staffer that is in charge of this index indicated no awareness or concern with quality adjustment, really making the point we reserve our quality adjustment for very different sorts --

DR. NEWHOUSE: Quality adjustment isn't quite --

MR. GREENE: New product adjustment, the same

general question.

DR. NEWHOUSE: So they're just ignoring it?

MR. GREEN: Yes, right.

MR. HACKBARTH: So that's good from our perspective. Okay.

DR. LOOP: Before I get into the options, I wonder if the cost of blood nationally is not underestimated, because there has been some testimony that the bill nationally is more than $4 billion. So Medicare would account for at least half of that.

By our calculations, this would not be 0.1 percent, which I'm afraid influences our thinking. It might be closer to 0.5 percent, the price increase. And if that's the case, then the high users of blood, which are not spread evenly across 5,000 hospitals, might have as much as a 1 percent cost increase.

This worries me that our original numbers are perhaps not correct and the small price increase is influencing the way we choose the options.

MR. GREENE: I based my 0.1 percent on starting with that 0.6 percent share used in marketbasket before 1997, which is also consistent with the numbers I get from

my patient stay analysis, Medicare data. And say with a 20 percent increase in that, that adds 0.1 percentage point to overall hospital costs.

DR. ROWE: If we go in the direction that's proposed -- and I certainly support paying for this somehow, even though everybody seems to think it's a small amount, because I remember it seeming to be a big number in my budget, a lot of patients get blood. In the outpatient department, they get it from the visiting nurse. Increasingly patients are managed outside the hospital who are Medicare beneficiaries. So I want to make sure I understand how, if we make this change in this marketbasket on the hospital payment, does that influence the outpatient payment for blood or Carol's staff hanging blood in the home?

MR. HACKBARTH: The question asked was specific to hospital inpatient PPS. That's what we're addressing here.

MR. GREENE: Yes, and that's all our analysis addressed.

DR. ROWE: But Congress may not be aware. Our job is to answer that question, but also not to put blinders on. I mean, if Medicare beneficiaries are getting blood in the

outpatient department which is also virally inactivated and leuko-reduced and everything else, we just want to make sure -- the economists here have taught me over the years that you don't want to set up a situation where the cost is deciding the site of care. Isn't that one of the rules? Or the payment is inducing the site of care.

We don't want to pay very well for an inpatient transfusion and not an outpatient transfusion, and wind up having that drive the site of care. Right?

DR. NEWHOUSE: Alas, it's a principle and not a rule.

DR. ROSS: I think it's reasonable to expect though that when CMS is revising the marketbasket and doing so on the inpatient side that it's going to look at all the price indexes that it uses.

MR. ASHBY: There's only one index. There's only one index that's applied to both inpatient and outpatient. So if you solve it for inpatient, you automatically solve it for outpatient.

DR. ROWE: But we might have a sentence in the narrative that says they should be aware of that.

MR. MULLER: One of the questions last time, when

we went through all the reweightings discussion and so forth, given the 1 percent increase that you've just estimated, when would this take effect? The marketbasket is done this year or next year. And the reweightings that Joe was educating us on last time, when would that take effect as it reweights against the charges for the DRGs?

MR. GREENE: If it proceeds on the schedule we're talking about, the new marketbasket, revised marketbasket and other factors would be included in the PPS proposed rule next spring and then reflected in payments in October.

MR. MULLER: I'll make the point again I made last month. 0.1 percent these days can be, depending on the inflationary value, can be a big number or a small number.

MR. HACKBARTH: Any other --

DR. NEWHOUSE: To go back to Ralph's point about reweighting, that's the answer, I think, to Floyd's issue that it's a one-time hit insofar as the difference across hospitals is really a function of surgical volume in use of blood. So that once it feeds into the weights, that will pick that up.

DR. LOOP: But we have to discuss what we're going to do in the interim until these are picked up because

that's a big expense for some of the high users.

MR. GREENE: I looked at the effect on weights, and it's modest. A lot of weights go up, looking at the possible increases in charges, but only a slight amount because these cases typically are very expensive cases. So even a large blood cost is a small share of total cost.

MR. HACKBARTH: Refresh my recollection about the update.

MR. MULLER: I would just wonder if -- I think Floyd's point, and I would make mine and maybe some others. It can be a very high proportion of costs in some of these. It can be 25 or 30 percent of the costs in some of these cases.

MR. GREENE: Medicare data shows a few with more than 10 percent.

DR. ROWE: Ralph, you're thinking of the same experience I had, which is the hemophiliacs, and they probably are not Medicare beneficiaries. Those are the big, big expenses, huge utilization. That may not be relevant to this population.

MR. HACKBARTH: Let's talk about where we left the update last spring. As I recall, in essence what we said

was we didn't have reason to disagree with what was written in current law, which was marketbasket minus 0.55 percent. So in that decision, and the wording of it, we acknowledged that we're talking about a range around this. And we just couldn't say that this was not the right number.

To now then come back and say we've got to reopen that decision for something of this magnitude, I think feels to me inconsistent with the spirit of the March recommendation, which was this is a rough justice that we're talking about. And now we're talking about a relatively small cost. The two just don't go hand in hand.

Now if we had said we can account for everything and marketbasket minus 0.55 is precisely the right answer, now we have to update that to reflect this small amount, that might make sense. But that's not what we said. We said this is really crude. We acknowledged the reality that it's really crude.

So I just don't feel like going back for this small a number would be consistent.

MR. GREENE: In effect you could say marketbasket minus 0.45 is now our chosen number. Does that make sense as a change?

MR. HACKBARTH: I don't think that's consistent with the spirit of our spring analysis, and the other things that we have.

DR. ROWE: If that's not where you want to go, where do you want to go?

MR. HACKBARTH: I've got a suggestion on the draft recommendation, the language of it, which I think streamlines it a bit. I suggest we say that when CMS next revises the hospital marketbasket it should explicitly account for the cost of blood. And then we can, in the text, talk about the indexes and that sort of stuff. And just have a simple straightforward statement.

MR. GREENE: And eliminate both the bullet points in the recommendation, moving them into the discussion language?

MR. HACKBARTH: Right. When CMS next revises the hospital marketbasket, it should explicitly account for the cost of blood.

MR. GREENE: That's the entire recommendation?

MR. HACKBARTH: Right. As opposed to the current situation where it's like chemicals and...

DR. REISCHAUER: That's just a little less

specific but it's the same thing. And I thought why we were into this game at all was not because of where we are today but looking out 10 years and understanding what's likely to happen to our ability to refine blood products. This might, over time, be a component. I mean, I don't lose sleep when I look at this and see that, relative to the overall operating costs per discharge, the differences here are trivial. What might occur, I think, in the future.

MR. HACKBARTH: One of the reasons I like the revised language is it's a little stronger than one that has these technical statements in the bullets. This could be a big factor down the road. We ought to explicitly account for it. And then we can talk in the text about the mechanisms.

MR. GREENE: One possible interpretation of that might be just point one. Do you want us to make clear that it's either one or two? Or do you just want point one?

MR. MULLER: Glenn, the way I read yours is to mean one. Is that correct?

MR. GREENE: Or one or two, both in a sense explicitly.

MR. MULLER: The problem I would say with two is

the problem we had five years ago when they lumped it into chemicals. And we wouldn't want to define this problem away by somebody saying oh, it's trivial anyway. The whole point of this long discussion was it may be a big cost, as Bob just said, and therefore we should recognize it. So if your wording means one, then I think it's a good wording.

DR. NEWHOUSE: Let me suggest a friendly amendment because I worried about the same thing. CMS could say their index now specifically accounts for it, they just measure chemicals. So it should use an index that measures the cost of blood.

MR. GREENE: Because the biological index that we discuss does indirectly, 10 percent of that is blood costs.

DR. ROWE: From a clinical point of view, in the evolution of things, this is not a biological, in the biological category or the chemical category. It's its own category. It's no longer blood, it's platelets, plasma, packed red blood cells, and this and that. It's become a whole category itself, and that's what we're saying is we don't want to dump it into one or another and we should recognize it as an emerging category.

DR. ROSS: Let me propose with the simplification,

that that gets at the objective here. The bullet points or the friendly amendment are sort of means to that objective. We could incorporate those in text, I think, just as easily. But you want us to make sure blood is explicitly taken into account.

DR. LOOP: This will take a couple of years to get in?

MR. GREENE: On the expected schedule, it would take effect next October 1st with payments beginning October 1st. We don't know that for certain, but given the anticipated schedule.

DR. LOOP: Since the blood prices went up in July, that means more than a year of absorbing pretty large costs for those hospitals that are large tertiary referral centers that have a big Medicare population. Are we sensitive to that?

MR. HACKBARTH: I guess the issue, Floyd, is is this, in fact, large in the grand scheme of things?

DR. LOOP: I can tell you from my personal experience that it's not a 20 percent increase, it's 30 percent where we are. And it costs our hospital $2.5 million.

MR. HACKBARTH: I guess the question is, what is the base? What is the denominator on that? And the denominator is very large. So as a percent increase, this is not very large. I think that's what the argument's about, or the discussion is about.

DR. LOOP: It's still money. It may not be large but...

DR. ROSS: I guess the point I would make earlier is that again, we're focused on one particular item, the price of which we know has gone up. But what we haven't examined also is all the other inputs to the process this year whose prices have gone down, whether it's been recent changes in fuel oil or anything else. And it makes it difficult just to pull one thing out and say yes, this one has gone up. There's no argument there. We know that.

DR. LOOP: Yes, but we're not transfusing fuel oil. We have a problem --

DR. ROSS: Actually, according to the marketbasket index, you are.

[Laughter.]

DR. LOOP: I think you're being insensitive to a large component of the hospital industry by saying that over

the next 15 months or so, they just have to absorb the cost. Now if you spread it all across the hospital industry it's almost a rounding error, but not for the high end users.

DR. REISCHAUER: But the way our system works, when prices are rising, hospitals get hit. And whether it's fuel oil or anything else, when they're rising slower than they did the year before, the index, in a sense, overcompensates.

DR. LOOP: But, Bob, this is not 1970. There's less padding in the hospitals now. That's the big problem. And there's barely a profit margin. When you add unreimbursed costs to it, even if it's for a year or so, it makes a big difference.

MR. GREENE: Just one point. The 20 percent really is an exceptional number. The PPI was going up a little bit less than 10 percent, and actually declined last year, and is now increasing again. So you shouldn't think of this 20 percent curve that's going up nonstop and continuously. That's the exception.

If anything, in 2000 the PPI went down.

DR. ROWE: Is there any way to -- what we want to

do, if I'm listening to what Floyd's saying, what I'm hearing is that we're going to make this change in the due course of things and we're shining a light on blood and blood products as it may emerge as a future issue that stands upon itself as important. But in the usual course of things, the payments will not increase for some period of time.

Floyd's point is there are some hospitals which are particularly susceptible to the adverse effect of this uncompensated increase in price. Do we have any history of dealing with that kind of a question, so that some subset of hospitals that are particularly high users of one or another service get a corrected payment in some way? Has that ever happened? Does Medicare ever do that?

DR. NEWHOUSE: Not that I know of, and it would land us in a much more general problem, which is that basically we use the same marketbasket weights for every hospital. The issue here is that not every hospital has the same marketbasket. But then you open yourself up to every hospital coming in and saying well, we have a different marketbasket than the average and this particular component went up. Therefore we want relief.

The system would just break down.

DR. ROWE: I'm just asking. For all I know there was some mechanism that had been used at some point.

MR. MULLER: Joe, how quickly, let's say if these 20 percent increases that should, other things being equal, kick these DRGs into outlier status more quickly, right? Or not?

DR. NEWHOUSE: Yes, that's also true. So to the degree that that's true, that would take effect immediately. But I wouldn't count on much relief from that, because the outliers are still a pretty small fraction of cases. But yes, it does help.

MR. GREENE: It's 20 percent on 5 percent costs.

MR. HACKBARTH: It feels to me like we're covering the same ground over and over.

DR. LOOP: Let me introduce a little new ground. I thought we were going to review the DRGs that were involved with the high blood usage? I think, as I remember from last time, we talked about 132 DRGs or something that had some kind of blood usage related to them. Is there not a way, for a short period of time, to add something to the blood DRG that would compensate the hospital in the short-

run?

MR. GREENE: I've looked at the DRG distribution in changes, an estimate of what would the impact be when we recalibrate DRGs, looking at the impact of a 20 percent increase in blood product costs on charges. And there I found 132 DRGs being affected positively, have blood costs that would lead to higher charges. But none increasing by as much as 1 percent. None with relative charges increasing as much as 1 percent. So there is an effect, but it's a small effect overall, even on the blood use DRGs.

MR. HACKBARTH: Floyd, let's think for a second about the process by which changes like this would be made. If in fact, they require legislative change, then you're talking about it, in all likelihood, happening next year for implementation at the beginning of the fiscal year anyhow. And so you haven't really solved the lag problem if that's the problem we're going after. It's not like these things will happen instantaneously.

DR. LOOP: That's the problem. As Jack pointed out earlier, there's going to be new technologies to remove all pathogens from blood, and that's going to jack the price up another 20 or 30 percent, and then there will be another

lag period. So we're going to face this again.

DR. ROSS: But a marketbasket that better accounts for blood products, again in terms of making updates, it's a forecast marketbasket. And looking forward with a separate component, one would hope that those additional increases down the road could be taken into account.

MR. HACKBARTH: We need to bring this to a conclusion. What I propose we do is vote on the recommendation that's before us as amended. Let me go back and restate what that is.

Then the issue that we seem to be hung up on is whether something needs to be done during this lag period. And if Floyd or another commissioner wants to make a proposal on that, we can vote on that as well. I feel like we're just sort of stuck here, going back and forth over the same ground.

DR. LOOP: The problem with that, with making a proposal for a short-term fix is that it either sets a precedent and other people would put their baggage in on it. I don't know how you can make a proposal to this, but you have hundreds of hospitals that are affected by huge increase in prices for blood. And it will affect their

bottom line.

So I think the Commission has to be sensitive to that. I don't know how to fix it in the short-term because there's no precedent for it.

MR. HACKBARTH: So you're saying that --

DR. LOOP: If you make a pass-through or you add something on to a DRG, then you guys have effectively argued that this --

MR. HACKBARTH: -- will be delayed and will open the door.

DR. LOOP: Exactly.

DR. NEWHOUSE: Also, I don't think HCFA would have statutory authority to do that unless it was budget neutral, in which case you'd wind up taking money away from other hospitals. And then they would come in and say why are you taking it away.

MR. HACKBARTH: As an add-on it has to be a statutory change, which will result in lags.

DR. ROSS: Can I propose then at least to add text language in here noting that the distributional impact is concentrated in particular DRGs and more likely to be in particular kinds of hospitals? Does that address part of

it?

DR. LOOP: I appreciate that, Murray. All advice should be accompanied by a check.

MR. HACKBARTH: Are we ready to vote?

MR. MULLER: This is your wording?

DR. ROSS: The wording is, when CMS next revises the hospital marketbasket it should explicitly account for the cost of blood and blood products?

DR. ROWE: Blood products.

DR. ROSS: Just blood products. I'll read it again.

When CMS next revises the hospital marketbasket, it should explicitly account for the cost of blood products.

MR. MULLER: Would you mind my suggestion, [inaudible].

DR. NEWHOUSE: I agree. CMS can say what they're doing now.

MR. MULLER: So if you wouldn't mind keeping point one and scratching point two, because two maybe gets us in the kind of difficulty we had the last five years.

DR. ROWE: We want to get it out of chemicals and

biologicals rather than have them saying we are explicitly including it.

DR. REISCHAUER: I don't see that saving the first bullet changes it at all, because they could say well, we'll do chemicals.

DR. ROWE: But it's not a separate component.

MR. MULLER: I was just trying to strike two.

DR. NEWHOUSE: That explicitly measures the price of blood. It's a separate component that explicitly measures the price of blood.

DR. ROSS: That's where we were.

MR. HACKBARTH: Maybe in the text we can say, we're not talking about a chemical surrogate for blood. What this means is what it says on the face. We want to measure blood, as opposed to trying to fiddle with the recommendation language.

MR. GREENE: There's language in the report already talking about the chemicals versus blood.

MR. HACKBARTH: I think in the context it's clear that we're not happy with the current situation.

All opposed?

All in favor?

Abstain?

Thanks, Tim. Pass-through payments for hospital outpatient PPS.

DR. WORZALA: Good afternoon. Dan and I will be discussing how Medicare pays for technology in the outpatient PPS. To refresh your memory, the Commission made recommendations on this topic in the June 2001 report and submitted a comment letter on the August 24th proposed rule. Since then a final rule has been issued.

The first part of our discussion will be a brief primer on the pass-through mechanism used to pay for certain technologies in the outpatient PPS. Then we'll turn to the treatment of the pro rata reduction in the 2002 pass-through payments in the November 2 final rule. And finally, Dan will present for you some alternative ways to pay for technology in 2003 and beyond.

Congress was concerned that the 1996 data used to set payment rates did not include the costs of newer technologies. Therefore, the BBRA mandated that supplemental payments be made when certain drugs, biologicals, and medical devices are used. That additional payment, called a pass-through payment is meant to cover the

incremental costs of the item plus, for an example, when a pacemaker is implanted the hospital receives the standard payment set for that service plus an additional amount calculated from the hospital's reported cost for the pacemaker itself in the event that the costs of the pacemaker are higher than the device costs that were already included in the standard payment.

Hospitals receive pass-through payments for each eligible item for two to three years, and after that the costs of these items are incorporated into the relatively weights.

The provision is meant to be budget neutral with spending on pass-throughs limited to 2.5 percent of total payments. However, through administrative action, and at the request of Congress, budget neutrality was not maintained in 2000 or 2001. So there were additional funds flowing for these items.

That brings us to 2002. In its November 2 rule, CMS estimates that next year pass-through payments would account for 13 percent of total payments in the absence of the 2.5 percent cap. CMS also estimates that maintaining the cap on spending would require an approximately 81

percent reduction in each pass-through payment. The law does require them to make those pro rate reductions if they estimate that the cap would be exceeded.

Both price and quantity factor into the estimate of pass-through payments. Administrative and legislative actions did increase the number of items eligible for pass-through payments. In addition, the payment mechanism set in place provides incentives for hospitals and manufacturers to increase their prices, thereby paying too much for certain items in the absence of the pro rata reduction. So that's how we got to 13 percent of total payments for pass-throughs.

To avoid such large reductions in the pass-through payments, CMS has decided to fold 75 percent of device pass-through costs into the relative weights for the related service. Your briefing material describes CMS' methodology for doing this, so I'm not going to go into details here, fortunate for all of us.

But taking our example of pacemaker insertion, it does mean that the relative weight and therefore the base payment will increase for that service. This will leave a smaller share of the device cost to be covered by the pass-

through payment. That means that in toto, fewer technology costs will be flowing thorugh the pass-through mechanism and that will result in a smaller pro rata reduction. However CMS does estimate that there will still be some measure of pro rata reduction.

Under this action, CMS will maintain the 2.5 percent cap and the budget neutrality aspect of the pass-through payments. In addition, because any recalibration of the relative weights must be done in a budget neutral manner, the fold-in will also shift payments among services.

In an additional step and to further limit the reductions in the pass-through payments, CMS recommended that Congress pass legislation allowing the funds allocated for outlier payments to be combined with the pass-through allocation only for the year 2002. This would increase the funds available for the pass-through payments by 2 percent of total payments.

It's important to remember, however, that both the pass-throughs and the outlier allocations are budget neutral, meaning that conversion factor is decreased to fund them.

The action taken by CMS will increase payments for

services that use medical devices eligible for pass-through payments. We have estimated that total payments for these services, that is the standard payment plus the pass-through payments, will be $800 million to $1 billion higher than they would have been if the full pro rata reduction had been made.

However, because the recalibration of relative weights is done in a budget neutral manner, as required by law, the fold-in will decrease payments for all other services. We have estimated a reduction in the range of 4 to 6 percent.

The November 2 rule did not include the actual APC groups or the relative weights. CMS has stated that they will be published in an additional rule next month. Operational systems may not, therefore, be in place to make payments under the 2002 regs come January 1. And some sort of interim payment method may be required.

So hopefully, this part of the presentation has helped you understand how Medicare will pay for outpatient technologies in 2002. Dan will now discuss some alternative ways to pay for technology in 2003 and beyond.

DR. ZABINSKI: Now the policy actions that Chantal

just discussed failed to address some important problems in paying for technologies in the outpatient PPS. We have identified three policy alternatives that would address those problems.

One option is for CMS to continue the pass-through system but to make some modifications.

A second option is to pay for all technologies on a fee schedule outside of the outpatient PPS. A third option is to phase out the pass-through payments and reimburse technologies only through the base payment rates in the outpatient PPS. On the next few slides, I will discuss the advantages and disadvantages of each of these options.

The first option of continuing the pass-through system is the advantages that the system is already established and that it facilitates payment for new technologies because there is no need to wait for the data necessary to establish payment rates or service categories. But the pass-through system imposes an arbitrary cap on spending of new technology and it places an administrative burden on hospitals and CMS to process the special information necessary for pass-through payments.

Also, it distorts relative payments in favor of services that use pass-through items. This is because the base payment rates in all APCs are reduced by the same percentage to make pass-through payments budget neutral, but the pass-through payments themselves are not reduced by that percentage. This problem is exacerbated by incentives for hospitals to increase the reported cost of pass-through items to increase pass-through payments.

If CMS chooses the option of continuing the pass-through system, the agency and the Congress should address three additional issues. First of all, the pass-through system should exclude items whose costs are reflected in the data used to calculate the base payment rates. Pass through payments for these items are not necessary because the base rates take their costs into account. But this action would require legislation because a BIPA provision makes such items eligible for pass-through.

Second, CMS and the Congress should replace the facility-specific pass-through payment for devices with some sort of national rate system. The facility-specific payments of charges adjusted to cost give hospitals incentive to increase reported cost by raising its charges,

and thus increasing pass-through payments.

Finally, pass-through payments should reflect only the incremental costs of the pass-through items. Currently, the incremental costs are determined as the reported cost of the pass-through item minus the cost of the item being replaced in the applicable APC group. But the costs of the item being replaced may be under-represented in the APC group, so the amount of the incremental cost being calculated may be too high. Consequently, pass-through payments may be higher than they should be, which increases the likelihood of exceeding the 2.5 percent cap.

The second option for paying for technologies is to remove all technologies from the outpatient PPS and pay for them using a fee schedule. This would eliminate the need for pass-through payments. The advantage of doing this is that it would no longer distort the relative payments in favor of services that use pass-through items and it avoids cost-based payments which give providers and manufacturers incentive to raise reported costs to increase pass-through payments. The disadvantage is that it would require unbundling, which can lead to higher expenditures on technologies through increased use and upcoding.

Finally, the third option for paying for technologies is to phase out the pass-through system and pay for all technologies under the base payment rates. This would no longer distort relative payments in favor of services that use pass-through items. Also, it would remove the bias in favor of using new technologies because of pass-through payments exceeding the acquisition costs of the items. Finally, it would reduce the administrative burden faced by hospitals and CMS.

The disadvantage of doing this is that we may underpay for high cost new technologies, causing hospitals to choose not to use such technologies.

Just in closing, I'd like to say that our intention for our analysis of these options is to lead to a chapter in the March 2002 report. We ask commissioners to provide comments on these options or other options they may have considered. We would especially appreciate their thoughts and directions we should take that might lead to recommendations.

MR. MULLER: I have a question and a comment. In the text you point out that CMS has not been able to, in a sense, deduct the cost that's contained in the APCs, and

therefore, in a sense, exacerbating the amount that the 13 percent is over the 2.5 percent.

Roughly, do you have an estimate of what if they had been able to do that? If they had been able to deduct that from the pass-through payment, how much -- instead of 13 what would it be? Would you have any sense of that?

DR. ZABINSKI: Actually, the 13 percent in 2002 does make a deduction for all pass-through items. Previous to 2002 they weren't able to do that. The problem is that the amount of the pass-through items in the base rates for devices speculated that it's under-represented. But how much under-represented is hard to tell, so I wouldn't know how much exactly that would reduce the 13 percent. It would make it lower, but I have no idea by how much.

MR. MULLER: I have another question, but I think in the flow of the conversation I'd rather come back to it later.

DR. STOWERS: I'm probably really going to show my ignorance here. If we were getting rid of the pass-through and we're folding it into the APCs, then it would be taken out of all of the other APCs or from all hospitals then; correct? So would we not have the cost borne for this

technology also affecting the hospitals that are not using that technology? So we would be taking that 4 to 6 percent drop, or whatever it is, out of the small community hospital or whatever? Am I making sense in that?

And those are the ones already that had the lowest Medicare margin.

MR. DEBUSK: Ray, about 8 percent.

DR. STOWERS: So I'm really wondering if this is an appropriate way to pay for the technology in centers that are using a lot of technology is to lower the base payment of all the hospitals. I just bring that up.

DR. NEWHOUSE: Ultimately this is the new technology problem we were dealing with blood. It's the same problem and it does apply to both inpatient and outpatient. IT's just that the Congress has put an explicit adjustment on the outpatient side and not on the inpatient side.

Within this context, I don't seen an obvious answer. Every course has its own problems. So it's a question of which set of problems we'd rather have.

I think I tend to come out liking the fee schedule, but I could be talked out of that feeling. Then I

think I like the modifications to the pass-through system. But it's an issue of how fast we think that the base rates will be updated for new technology. How important the legs are. Will hospitals adopt the new technology and take the one-time hit until the base rate gets updated as it was in the blood case?

The problem with the pass-through, which we're seeing, is that -- particularly for devices or technologies with a high Medicare share -- there's a tremendous incentive just to price it to the hilt on the part of the manufacturer or supplier. That then leads you in the direction of a fee schedule which is basically then a price control. But I don't see any other good option, no happy outcome.

MR. HACKBARTH: Is there a reason for thinking that the technology problem on the outpatient side is different than on the inpatient side? Congress opted to do this pass-through. Was there an analytic basis for that, as opposed to a political basis for it?

DR. WORZALA: Can I speak to that a little bit? This goes back -- I actually misspoke at the beginning of my presentation. It was the March report when we last spoke about this issue, where we addressed how technology is paid

for in both the inpatient and outpatient setting.

We pointed out some differences in the two prospective payment systems that may lead us to think that separate treatments are appropriate, things like the smaller unit of payment on the outpatient side, the fact that on the outpatient side you pretty much need a code to be paid for anything, as opposed to a DRG where you can choose to use different technologies within the DRG payment without a code.

So these are some of the differences that may suggest different payment mechanisms.

Also, to refresh your memory, BIPA did include provisions requiring additional payment for new technologies under the inpatient PPS. And those systems have been further developed by HCFA.

DR. REISCHAUER: Dan, just if you could enlighten me. We have a situation where we have 13 percent now. Part of that is attributable to the fact that there's technologies that are really in the base that shouldn't be there. They're there for political reasons. What if that weren't the case? Do we know how much that would lop off?

DR. ZABINSKI: I don't know.

DR. WORZALA: I think the only thing we can say is that it would be significantly smaller. I tried to allude to this. What's accounting for the 13 percent is two things. One is the incentives in the system to overstate price, and the other is a considerable expansion --

DR. REISCHAUER: I was going to ask you about that next.

DR. WORZALA: A considerable expansion in the eligibility criteria for the pass-throughs between BBRA and August 1, 2000. Both administrative action and legislative action did explode the number of items that would flow through the pass-through mechanism, so that over 1,000 devices were eligible as of January 1, 2001.

So all of that will sunset in 2003 and be folded into the base so that moving forward we can expect that it will just be truly new technologies with a much narrower set of criteria applied by CMS for eligibility for the pass-through payment. So we can expect that it will be much smaller than 13 percent but we can't, obviously, know what the number will be.

DR. REISCHAUER: So there's a big chunk, this significant chunk of the problem is going to go away.

DR. ZABINSKI: Hopefully.

DR. REISCHAUER: If the political system doesn't respond and continue. But then there's the notion of moving to national rates. I'm thinking about how big -- you don't, as a single hospital, have a direct, but you certainly have an indirect or a collective incentive to jack up your prices as well. Is there an alternative, like taking rates out of what the VA pays or something like that?

MR. MULLER: In fact by taking it out of the APCs, whether it's four to six, you get hit because it is a pass-through. You don't get those "jacked-up rates." So by having it folded in the way the November 2nd rule does, in a sense you get penalized for having this be so big. You follow me? If you show no judgment for what you pay for these devices and they get folded into the APCs, your APCs go down. So in a sense, a hospital gets penalized --

DR. NEWHOUSE: The APC is a national rate.

MR. MULLER: I was just asking Bob a question. I would think hospitals get penalized for not being diligent purchasers.

DR. REISCHAUER: Are you telling Dan that he's right except he has the sign wrong?

MR. MULLER: The device manufacturers have an incentive to jack up. The hospitals get penalized for not being prudent in resisting that jacking up.

DR. ZABINSKI: I don't know, I see it as, I start thinking of game theory. If one guys does it and nobody else does, he wins. If they all do it, they all lose.

MR. MULLER: But the hospital doesn't get the mark up. It gets passed through to the device manufacturer, correct?

DR. NEWHOUSE: Ralph's point is, given this 75 percent, the 75 percent is averaged over all hospitals. So it's not hospital specific, whereas the pass-through is. That's really what's going on. So it doesn't -- Ralph's right then, it's not to the hospital's advantage.

MR. MULLER: Yes. It's a disadvantage.

DR. NEWHOUSE: For that 75 percent.

DR. ROWE: It's actually 62 percent because you take 75 percent and you multiply that times 0.83, so you get 62 percent of so.

MR. MULLER: Right. The point is still, there's a disadvantage to a hospital by not -- of course, they have no choice in what they're paying if they're paying the average

price which is set by wholesale prices set by somebody else.

MR. DEBUSK: Chantal, after 2003 and this all rolls back into the APC, then from that point on is new technology going to be new for 12 months and then rolls back?

DR. ZABINSKI: Two to three-year timeframe by law. BBRA specified that, each category or drug has to be eligible for two to three years.

MR. DEBUSK: Let me make a statement here about, you look at the effect of the new technology and the way the system works now, somehow we've got to unbundle this technology because we can't take new technologies, new cost, new procedures and every so often we take and look at this, it becomes budget neutral. Who pays for it? Then the people it's really going to hurt if we don't unbundle it is going to continue to be the small hospital or the small urban hospital or mid-sized rural hospital.

This is one of the things that's breaking their back now is because as higher technologies, new technologies are paid for, then their APC codes, which they do a lot of the routine APC codes, this just takes money right out of their pocket. At the same time, if you think about it,

you're taking into consideration only 4 percent of the APC codes actually have a device tied to it.

DR. WORZALA: I will try to give you Julian Pettengill's answer to that question which I've asked him repeatedly, and he'll back me up if I get it wrong. The notion is that under normal circumstances, if you're not taking this big 13 percent chunk and moving it over all at once -- it's not exactly 13 percent. But anyway, when you recalibrate the relative weights that is done in a budget neutral manner so that there is decrease in the relative weights for lower level services and increase in the lower higher services.

But what you are then doing is putting an update in as well, and the update to the conversion factor should be including the medical inflation of new technologies. So that that raises payments for all services.

DR. NEWHOUSE: But how is that computed? We haven't exactly succeeded in doing a wonderfully precise job on the inpatient side.

MR. DEBUSK: There's some difference in this median and mean. Sometime, Dan, I'd like for you to explain that to me, how they're calculated. But that's another

subject.

DR. STOWERS: I may be being redundant here, but when we say that the problem is going to go away, are we not saying that it's going to get folded in and lower the overall base rate, because that's going to fold in in a couple of years or whatever. Then again we're, not being redundant with what Pete is saying, is we just keep lowering the base down so that those that are not using the technology are going to go on. So if we adopt this over the long haul then it keeps getting worse and worse with time.

I think the problem is that we've got to face with Congress is that the 2.5 percent is not covering what happened here. Trying to do this under some kind of a 2.5 percent base. So we can't raise the 2.5 percent base so let's start penalizing the small hospitals and all of that, and just keep taking it out of their base, and we're going to expect the small hospitals to pay for the technology in the big centers, which is what this really sounds like.

Maybe I'm misunderstanding it, but in the long run this is where that would head I think. So we've got to face the fact that this 2.5 percent is not covering what happened here. I think that ought to be very explicit in our report.

Number two, I think we ought to -- if we've got the time here, and it looks like we do, I think we ought to run out the impact numbers on this over a period of time for the different size hospitals to make it very explicit what's happening to who in this particular process. Because I think Congress needs to be aware of what's happening here.

MR. DEBUSK: Let me ask another question. Here they've taken this hit. Do they ever get this money back to catch up with this marketbasket? The marketbasket last year, they got an increase, and now here it's gone again. Do they ever get it back and going forward?

DR. NEWHOUSE: This is the scientific and technical advance number. In principle, if that is adequate, that's what's supposed to -- how this is supposed to be accounted for. One other note on Ray, in telling the Congress 2.5 percent doesn't do it, it's partly because we've set it up as a pass-through that it doesn't do it. That is, there's incentives to use more of it, price it higher, and so forth.

DR. STOWERS: The question is who pays for it.

DR. LOOP: If the 2.5 percent is still there, it still doesn't do it and I think that has to be reevaluated.

Maybe it's out of the purview of this chapter, but with all the advances in drugs, devices, biologicals, that figure is not right.

The other thing, now maybe I just don't understand this chapter but you've got one payment methodology for technology in the outpatient and one for the inpatient. They're not really compatible. And for progress it seems that you want to move a lot of the high cost inpatient to the outpatient setting. Now doesn't the incompatibility retard that progressive move of more procedures to a lower cost outpatient setting?

DR. NEWHOUSE: It's the other way around.

MR. HACKBARTH: Technology is more favorable on the outpatient side.

MR. MULLER: Favorable to whom?

DR. ROWE: To the hospital.

DR. NEWHOUSE: Shifting it out.

MR. MULLER: There is a technical discussion that's going on here, but an appropriate one. The pass-through goes to the manufacturer. There's this redistributional effect that hits all hospitals. It doesn't just hit the rurals.

So this is not a redistribution, Ray, I would say from the small to the big hospitals. I obviously don't want to rise to the bait, though I obviously have. So it's not a redistribution from the small to the big. It's a redistribution by taking a category of device and saying they'll be paid for it 95 percent of cost, and the cost, for the reasons you've all suggested, can go up more than other costs that are more constrained.

So it's that kind of redistribution outside of the outpatient setting, whether it's in a small or large hospital to device manufacturers, perhaps -- probably reflecting some outside reality, which is why they got it through. I think Joe's preference for a fee schedule at least puts some constraints on that in that sense. So I think it has a lot of virtue in going in that direction.

But as long as you have, in this case like the fold-in, on the one hand there's a lot of sympathy around this table for having the appropriate technology enhancing the lives of beneficiaries and getting it out there. On the other hand, given budget neutrality if getting those technologies to beneficiaries just gets folded back into the base rates there's a major redistribution going on of

service that may not necessarily positively affect beneficiaries in the long term.

So that's, I think, the kind of question that's going on here is that, if you have too much of the -- whatever the right number is. If the 2.5 is blown by too big a number, I think we would all say 13 versus 2.5 is too big an overage of a ratio. By then folding it back in it takes away a lot of the power of supporting the introduction of new technology in the first place.

So I think going back, if I could just briefly, on the discussion we had on blood. One of the things we have to be thinking about, as you have, is how does this kind of science, technology, how does it get introduced appropriately and quickly, to go back to Floyd's point, into the payment system in a way that both advantages beneficiaries but doesn't have the kind of very distorting effect that seems to have occurred in this particular situation.

DR. ROWE: I want to go back to the principle or the rule that we discussed when we were talking about blood about not having the payments provide a distortion of the location where the service is provided. I want to make sure

I understand what the rules are here.

Let's take an example of a stent that's being used for an intravascular procedure, which is increasingly common and which I think in many instances can be done in the outpatient setting as well as the inpatient setting, for an aneurysm or really a major thing. Let's say the stent cost $10,000, which I think is not an unusual number for a stent, right, Floyd?

So what happens is if you have that -- if you're a Medicare beneficiary and the hospital does this and admits you, and you get exactly the same radiology suite and interventional cardiologist or vascular surgeon, whoever is doing it. The hospital gets paid for that DRG, if you will. Then if you count that as an outpatient rather than an inpatient, basically the same exact things are going to happen to the patient. They're going to be there for the same amount of time, et cetera.

Then the hospital gets paid 62 percent of $10,000 plus -- is that right?

DR. NEWHOUSE: Marked down by this 2.5 percent over 13.

DR. ROWE: I'm just trying to understand what

would happen, and would there be a distortion, and is that something that we should at least bring to people's attention? Is that a bad idea?

MR. MULLER: This is a major redistribution, at 13 versus 2.5 -- and I think as Dan pointed out, it's much less than 13. It's probably more like eight or nine. But it's a redistribution from outpatient settings in large, medium, and small hospitals to device manufacturers. That's the redistribution. It's from hospitals to device manufacturers, not from small to large hospitals.

In that spirit, my other point earlier, I see no reason to put the outlier pool in here as well. Given this is already a redistribution, why you would put the outlier pool -- the outlier pool is there for some purpose, some substantive purpose. Unless we have evidence that the outlier pool is being used for -- is not being used at all for the purpose for which it was established, why you would want to throw the outlier pool into this as well, to have even --

MR. DEBUSK: It's not being used.

MR. MULLER: They're recommending that.

MR. HACKBARTH: I'm just trying to follow where

you're going, Jack.

DR. NEWHOUSE: We're not recommending that.

DR. REISCHAUER: That's what CMS is doing this year.

DR. NEWHOUSE: That's what CMS is doing.

MR. HACKBARTH: So we have a system that is not neutral between inpatient and outpatient, and as currently constituted involves a significant redistribution, if Ralph is right, from all hospitals to device manufacturers.

DR. NEWHOUSE: It's really what we think is an artificially large redistribution because of the incentive of the pass-through system. There's always going to be --

DR. ROWE: So maybe our responsibility is to point all this out to Congress rather than to --

MR. HACKBARTH: Fair enough. But I hope we can go a little bit further and say, this is what we recommend to replace it. But that's where you were headed with that?

DR. ROWE: That's where I was heading was to say, rather than -- to step back and say, guys, we think you made a mistake. We think you did the wrong thing. Or these are the consequences, maybe unintended, now that we've thought about, or something like that.

DR. ROSS: That's absolutely where I think the Commission needs to go. I would just remind you that Joe opened up the bidding with, there are no good alternatives, at least there are certainly no perfect alternatives. You may have to use some other criterion by which to make some assessments, and think back to the issue on operational feasibility, regulatory complexity. All of those things are going to play in because all of the systems that we'll talk about, and options that we'll bring you, are going to have either incentive problems, redistributional problems, something you don't like. But you're going to have to make a call.

MR. HACKBARTH: But let's just build this one step at a time. Do we have consensus on the points that Jack has made, which is we've got a problem of not having neutrality between inpatient and outpatient.

DR. NEWHOUSE: You've got that across the whole -- we've got it for lots of reasons other than this.

DR. ROSS: But this may be minor relative to all the other on that interface.

MR. HACKBARTH: To me what it means is that you wouldn't want to be going down a path with the pass-

throughs, and unless there is some real or compelling reason to do that, because this is a major breach of the neutrality.

DR. NEWHOUSE: I would have said the more important point was the incentive, what Ralph was talking about and the incentives on the pricing and the device side.

MR. HACKBARTH: I don't think it's either or. I think it's additive.

DR. NEWHOUSE: It is additive, but I think -- my guess, I haven't looked at the numbers but my guess is this is actually not a major incremental distortion of the inpatient-outpatient decision.

DR. REISCHAUER: Just a point of clarification, Chantal, if you could. Is the first 2.5 percent, in a sense, free and clear, or have they reduced the APCs already?

MR. MULLER: They did it already.

DR. REISCHAUER: They reduced them already.

DR. WORZALA: That's correct. Yes, it's budget neutral so it was already reduced.

DR. REISCHAUER: It was budget neutral. It strikes me this whole discussion is part of a much, much

bigger problem, which is how fast should technology progress in the medical area, and what role should Medicare play in facilitating financing that? There is no right answer to that question. If you pay for it, they will come. It could be 40 percent, if you put the money out on the table.

We are a technologically biased society that always wants to believe that new is better, and whatever it is, improves things. But we haven't said a word about what the benefits are from this or how the benefits stack up against the cost. There's sort of a tone in some of this discussion that, sure, there's some incentives to do too much, but gosh, we're constraining this system unnecessarily, or below some optimal level. And I'm not at all sure we are, at 2.5 percent.

If we decide that that's the right pace of technological advance in outpatient, it should be maybe the same in home health, it should be maybe the same in inpatient. I'd like to see this placed in a larger context. Maybe only a few paragraphs --

MR. MULLER: Bob, I didn't hear that being said. In some ways I would say, the outpatient system is fraught with so many moving parts, such a lack of data, so much

confusion. Almost every negative thing you could say, you could say about the system. So to therefore say, but in this system that's fraught with all those challenges we're going to protect one part of it and take this money off the top really exacerbates a very difficult situation.

So I would say this is not something that I think is a great thing to do in a world that is so muddled, to protect one part of it and say, we'll take some money off the top in an incredibly muddled system where there's very little data, real information, as we discussed last time. So I'm not in favor of protecting this at a time when the system is going through such major transition and the data is lagging and faulty.

MR. DEBUSK: Bob, first of all, with all this new technology --

DR. REISCHAUER: I was hoping you'd come back --

MR. DEBUSK: We're trying to save your life, make you live longer.

DR. REISCHAUER: After another year of this you won't be trying to save my life, Pete.

[Laughter.]

MR. DEBUSK: Let me better understand, like a lap-

choles procedure, these numbers -- I think these numbers are right. But in the hospital, if you have a lap-choles procedure they pay some $4,500 for the procedure. If it's an outpatient, an APC, they pay $1,500. I thought the idea in trying to move stuff from in the hospital to an outpatient was to save the government money, to save Medicare dollars, to save cost in the whole system.

Now you come along and what's driving so much innovation with devices and what have you in this outpatient setting, you know a new technology -- I don't have to go over the advancements that are being made, and a lot of it is certainly tailored toward the outpatient setting because the surgery centers across this country are just exploding. Doctors are moving more and more of their patients to an outpatient basis and supposedly it's reducing cost, et cetera.

One of my contentions is that we got to be careful about what we're doing to the integrated health care system, the big hospital, because we know we've got to have that. There's a delicate balance here that I think we're going to have to address one of these days.

DR. ROWE: Pete, can I make a clinical point

though that's relevant to this and I think is important? If you just say we pay $4,500 inpatient, $1,500 outpatient; it's the same procedure, it doesn't make sense. The other clinical point is in fact that the patients who are going to get done in the inpatient are the 280-pound, 82-year-old diabetic patient with angina who needs different anesthesia, and monitoring, and care, et cetera.

Not all lap-chole patients are the same, so that the ones that are lower risk get done in a setting where there are less resources that are needed to be brought to bear to do it safely on the patient. So we just need to recognize that, that there is a natural selection of these patients to different environments, and that's part of justifying that differential in payment.

MR. DEBUSK: Probably there's more money made off of the outpatient at $1,500 than you make at $4,500 because of the complexity. But why cannot new technology and substantially improved technology, it looks to me like if we recognize this separately, put it together in such a way that after a product is approved by the Food and Drug Administration in relatively short order we address the features, the benefits, the value? Joe, maybe we go back

and set a rate for this product. But anything short of that I think we're -- I just don't see how we're going to get there.

MR. HACKBARTH: We've got to move ahead. This is something for our March report so we don't need to resolve it today. I'm not sure I hear a whole lot of consensus thus far.

DR. NEWHOUSE: I heard a little consensus on a fee schedule.

MR. HACKBARTH: I'm still at a higher level. If we can get as much neutrality as possible between the two settings, that would be a good thing. We certainly don't want to use payment mechanisms that result in redistributions to device manufacturers away from providers.

DR. NEWHOUSE: But even between hospital and outpatient, you've also got the ASC and the office which are not part of this that we're talking about, which may be quite relevant.

MR. HACKBARTH: Right. Fair enough. We have the overarching question that Bob has identified. The big policy question is, regardless of setting, how much do we want to pay for the new technology?

I don't feel like we have any agreement whatsoever about the specific policy options that were outlined. I'm just too confused myself to even have an opinion. So that's where I think we are right now. Are there any specific, very pointed questions, Dan or Chantal, that you have for us that would help you prepare for the next discussion on this?

DR. WORZALA: Would you like us to continue on the path that we've set so far of options, or would you like us to have more discussion of these bigger issues?

MR. HACKBARTH: I think that you need to drag us back to the options since ultimately that's what we have to produce. So that's a constructive role you can play.

DR. ROSS: What we'll bring you is some of the options, perhaps evaluated against some of the criteria that have been laid out in terms of clinical neutrality, and avoidance of distribution outside the system.

MR. HACKBARTH: That's great.

Okay, thank you very much.

We have a series of presentations now on assessing payment adequacy and updating payments. Nancy and Jack are going to do an introduction and then we're going to proceed through physician payments, home health, and skill nursing

facilities. This is our last session or group of sessions before the public comment period.

Nancy?

MS. RAY: The goal of this presentation is to review our framework for making update recommendations that we first presented to you in October. Now what we presented in October, our framework is pretty similar to what MedPAC has always been using. I just think that we have made what we are doing a little bit more transparent and explicit. Particularly in the kinds of information that we're considering and how we're considering information.

We decided to make our framework more transparent to address three concerns. First, in the past we have mixed consideration of the adequacy of current base rates with the update needed for the next payment year which has often resulted in confusion.

Second, we have tended to focus on narrow issues like how much to allow for Y2K costs while focusing little attention on whether payments matched the cost of efficient providers which has far greater financial implications.

And third, we have tended to measure the individual factors that may be affecting the adequacy of

current payments such as, in the inpatient arena, unbundling or upcoding. But given the difficult of measuring these factors it may be more prudent and productive to focus on whether payments are too high or too low rather than on how they became too high or too low.

Now immediately following this presentation we will be presenting three real world applications of our model looking at assessing payment adequacy and updating payments for physician services, SNF services, and home health services.

So as we can see in this diagram, and this is the same diagram basically we presented in October, our model for making update recommendations would routinely be divided into two steps. The first step is to assess whether the base payment rate is too high or too low. If evidence does suggest that the base payment rate is too high or too low, then the update recommendation would include an adjustment to the base payment rate.

The second step is to try to measure how much efficient providers' cost will change in the next payment year. Then the final update as depicted in the figure combines the two percentage changes. That's our update

recommendation.

Now the next diagram -- and again, we went through this in October but we wanted to remind you again. This diagram depicts the process of how we will be assessing payment adequacy for the six different services that we're going to be doing for this March. That's physician services, inpatient hospital, outpatient hospital, SNF, home health, and outpatient dialysis.

Now we are proposing to assess payment adequacy in three steps. First -- and this is the top left-hand box -- we will measure current Medicare payments and costs. That's modeling where we are right now. Now I want to point out two caveats with this step. First, measuring current Medicare payments and current Medicare costs, current isn't so current. We're going to be making decisions for payment rates in 2003 and the most current data we have is 1999. So that's one caveat.

The other caveat is for certain service areas, particularly physician services, we don't have information on costs, Medicare costs. So have this framework and we use the available information, whatever available information we have for each particular provider.

The second step is assessing the adequacy of payments. That is, determining where we want to be. We're talking about looking at the appropriateness of current costs and the relationship of payments to costs. The different pieces of information that are shown in the lower left-hand box help evaluate the appropriateness of current costs and the relationship of payments to costs.

For example, the rate of change in per-unit cost sheds light on the appropriateness of the cost base. However, changes in the produce must also be taken into account when you're looking at changes in per-unit cost. Pressure from private payers also gets at the appropriateness of current costs. For certain service areas we can look at evidence of access problems, and this may indicate that payments are too low relative to costs. For other service sectors we can also look at provider entry and look at volume growth. Extensive provider entry and large volume growth could point to payments being too high.

I want to note that margins are not included in the lower left box. The current costs are imbedded in the margin. But again, current costs may or may not be appropriate costs. So the margin in and of itself doesn't

tell you anything about where we ought to be. It tells you where we are right now and that is what we consider in our step one, that top left-hand box.

So now we go down to the policy factor box, which is on the lower right-hand side of the screen. This considers the following. If we thought that the current cost did represent efficient cost, then where should we set payments relative to these costs. I think this represents a range, not just a single point. While this is judgmental, I think we need to be explicit in our thinking and in our writing.

Now the third step in the process is to plan an adjustment to the payment or determining how to get where we want to be. In most situations, the adjustment would be a percentage increase or decrease to the base payment rate which is carried forward to the second part of the updating process. Now if we do find that the base payment rate is too high or too low we may want to consider phasing in large changes.

We also presented in October our approach for developing update recommendations. Again, we carry over the compensating adjustment if the Commission thinks, and if

evidence points to the fact that the base payment rate is too high or too low. At our October meeting we also proposed to anchor our update recommendation around the estimate of price inflation for each service area unless credible and sufficient evidence suggests that providers' costs are expected to significantly change due to the cost of medical advances, productivity gains, and one-time factors.

Our rationale for anchoring the update around the forecast of price inflation is that it is probably the most important factor influencing providers' costs in the next payment year, and it is the one factor that we can measure from year to year.

Now the model does account for other factors like the cost of new technologies, and productivity savings, and one-time factors. First of all, we are assuming that productivity gains made by providers will offset the cost of new technologies, barring compelling evidence to the contrary. So we are not ignoring these factors. And to the extent that there are issues that do not get addressed when developing update recommendations, they would get addressed in the review of payment adequacy in the next go-around.

This diagram, on the X axis we have the payment year and on the Y axis we're trying to assess payment adequacy. I think what this diagram shows is the uncertainty that is inherent in our process to assess payment adequacy and update payments. First of all --

MR. HACKBARTH: Nancy, just for the record, this is conceptual. This is not --

MS. RAY: This is very conceptual.

MR. HACKBARTH: There's no real data behind it.

MS. RAY: There is no real data behind this.

DR. ROSS: The goal here was to give a little bit of flavor to remind commissioners -- this is not in your handout because we've been working on this. But to remind you, we say repeatedly, we have data from '98, or we have data from '99. But just to locate you in this whole process -- and I'll let Nancy go through it -- but from what we know to what we're forecasting to what you're being asked to advise the Congress on.

MS. RAY: Thank you for clarifying that. So we are making payment update recommendations for 2003. That's our decision year. Where we are right now is in 2002. Actual data for services is either 1998 and/or 1999. But

that looks like that's going to be the latest actual data that we are going to have. For certain service areas we may have 2000 data. However, it's very preliminary. So now we're going to need to take this older actual data, some preliminary data, and make forecasts into the future, which is now, for 2001, 2002, and for our decision year 2003.

I think what this points out is that there is uncertainty inherent in making update recommendations and the uncertainty increases the further out in time you go.

A second issue I'd like to point out with this diagram is the adequacy zone. It's a zone. It's not a single number. It's a range. I guess at issue is how wide the range is. Again, I think this is very judgmental, but I think we need to be explicit from service area to service area.

Now a third issue I'd like to point out is concerning --

DR. REISCHAUER: I have a question here about the adequacy zone. I'm not sure what the word adequacy means, but I'm surprised that it seems to be level. We're in an era of growing prices and things, and I would have thought that the adequacy zone would have an upward slant to it. If

what we're talking about as adequacy --

DR. ROSS: It's in real terms. Your point is well taken. Again, all we're trying to illustrate here is that there's a range in which --

DR. REISCHAUER: We just did talk about increasing technology, but I won't bring that --

DR. ROSS: Fair enough. But there's a range in which you're going to have to make a judgment that payment rates are about right. That's all that red zone is trying to describe, what that range is.

MR. MULLER: Is that another way of saying margin?

DR. ROSS: No, it is not another way of saying margin. Because, for example again, one of the live policy issues you have to make a recommendation on is physician fees where we don't have a margin. You have to know that somewhere, based on what you know about access, what you know about participation rates, et cetera, that payments are in your -- instead of adequacy zone, commissioners' tolerant zone. That you know they're not too high, not too low.

MR. HACKBARTH: Just so I understand the concept here. Does this imply that recommendations about updates will be in the form of a range? Or is this still the prior

step of assessing the adequacy of current rates?

DR. ROSS: I think what this is trying to illustrate is, presuming that commissioners have a tolerance for a range of payment adequacy, and there's a lot of uncertainty about what the exact right update would be, the question is, do those areas overlap reasonably well? We have talked to you and we're going to keep talking to you through November and December about, again, anchoring an update decision around a marketbasket forecast, or I should just say a price index forecast, which by itself is a precise number.

But presumably you're trying to locate that number and say, given the current payments, given an increase of that magnitude, would we be comfortable with the outcome?

MR. ASHBY: Could I try to clarify one matter on the question of margins? That is that in a facility setting where we do have cost measures -- so this is bypassing the physician question now altogether for the moment -- the notion of payment adequacy really ideally ought to be payments relative to the efficient cost of providers, or the cost of efficient providers, if you will. So that if you were absolutely certain that the current cost base does in

fact represent the cost of efficient providers, then you could look at payments relative to those costs and it would take on the characteristics of a margin.

The reason why we're always sensitive to say, oh, this is just margins, is because if we look at the current margin it may very well not represent payments relative to efficient costs. We may very well think that the cost base is really too high, or in some situations like some rural facilities the notion has come out that perhaps the cost base is too low. So that's a very important caveat to just blanket talking about this as margins.

MR. MULLER: But having just the term adequacy, in some ways I could do a box that says, three-year-old data is one box, then I have three-year black box, then I have a line coming out called forecast. The notion of adequacy when the data is necessarily --

DR. ROSS: That would be another way of representing this.

MR. MULLER: Obviously, if you represent it as a three-year black box then people get a little bit more concerned about how good that is as a base for the future. So how we draw the picture -- so part of my concern is given

that at least in two of the big groupings that you have, hospitals you have three-year-old data and physicians you don't have cost data, the notion that -- you get into words like adequacy, which is a value-laden word. Then we have three-year lags and we don't have cost data on physician payments.

I think it implies there is more currency of adequacy, there's more current information on adequacy and more complete information on adequacy than we in fact have. That's my concern, that this three-year black box can have almost -- to use Bob's question or maybe it was Glenn's question earlier, that black box could be going up, could be going down, could by going sideways, could be rotating, could be whirling around. Therefore, the way in which the line comes out of it as a forecast could be going in quite a different vector than you might suspect.

DR. ROSS: But at the end of the day you are still on the hook for making a recommendation to the Congress on the payment update. I would stipulate to all -- I don't know about the rolling around part, but we'll stipulate to all of that. That's in fact precisely what this diagram is intended to drive home is that there's a lot we don't know.

In general, given the uncertainties on both the up side and the down side, generally that suggests some caution in decisionmaking.

But the point is, come the January meeting for publication in the March report, you still have to hit the end point on the update recommendation to the Congress. Because the alternative isn't to say, we don't know anything. Ergo, we can't make a recommendation. Or life is uncertain and we can't make a recommendation, because we still need to make one.

MR. HACKBARTH: Could we just let Nancy and Jack finish their presentation?

MR. ASHBY: I just wanted to point out one caveat about the data that would make it sound perhaps not quite as bad as Ralph just described it. Any little bit will help perhaps.

One maybe not that helpful a comment is that in ordinary years the actual data line would go up to 2000. We should have actual data for 2000 here, not 1999. This is an unusual year in that all the uncertainty has left HCFA behind with the processing. They've just simply been asked to do too much in too short a time, so we're not going to

have 2000 data as we normally would.

Then secondly, actually at least for hospitals we will actually have some preliminary data for 2001 because we did last year invest in a survey to give us a quicker time turnaround. so we will have some information that's a little more recent than you see there.

MR. HACKBARTH: So that implies, Jack, that the recent slowdown you think is a temporary one and won't last.

MR. ASHBY: I would certainly hope so. But again, there's no proof of that.

MR. HACKBARTH: That's why I asked.

MR. ASHBY: I can't be quoted on that because I'm not CMS. But we are certainly hoping that eventually we will get caught up and we'll get on the cycle that we had in the past.

DR. STOWERS: I just had a question. If we, like weather forecasters that make a forecast and then look back to see how close they came, could we run five-year numbers or whatever and say, we predicted something as a need or whatever in 2001 and how close did we come to what actually happened, and plot that over -- or is that something we wouldn't want to talk about?

MR. ASHBY: When the future gets here we can go back and keep score.

DR. STOWERS: I guess a way of maybe refining what we're doing.

MR. ASHBY: Yes, over time.

DR. NEWHOUSE: The problem is what we do affects what the hospitals do. If there's less money out there, other things equal, probably costs are lower. So there's a self-fulfilling prophecy.

MS. RAY: Moving on to the next slide. Next steps. Following this presentation, like I said before, you'll be seeing presentations on updating physician payments, home health, and skilled nursing facility services. In December you will also see presentations on inpatient and outpatient hospital update and dialysis.

The other presentation that you'll be seeing in December is a presentation on the measures of change in input prices for the six service sectors that you will be making recommendations on. Focusing the update recommendation around the measure of price inflation places great emphasis on using it as accurate a tool as we possibly can for this. So during the December meeting staff will

address price index issues in more depth.

MS. ROSENBLATT: I just want to make two comments, because that diagram -- Janet turned to me and said, that's kind of similar to what you do as an actuary, and it really is. We look at the past, and predict the future, and try to set premium rates. And like Murray said, I don't have the choice of saying, I don't have enough data, or I don't have a certainty and therefore I can't predict the premium.

But I do want to say that -- and there were a couple of us shaking our heads when Nancy pointed out 1999 data. I do think that it is just unbelievable that a program of this size can be permitted to not supply more current data because each year of uncertainty does make that cone of uncertainty increase. So I want to go on record to say that.

The other thing is, I think this is an interesting way of looking at the model. Could you put up the boxes for a minute? I just want to point out the market factor box and raise a question. The next to last bullet, entry and exit of providers, the market factor that goes into our analysis makes me realize, why did we restrict this model to the traditional program and not think about this model for

M+C where that box on entry and exit would be a lot of -- there's a lot of information in the fact that there's a lot of exit going on.

DR. ROSS: The shorthand answer from staff on that is, because given that the Commission has adopted the principle of local financial neutrality it means the only decisions you need to make are on the fee-for-service side and the rest of it flows through. The Commission last year said, make payments about equal to local fee-for-service adjusted for risk, which means once you make all your update decisions on the fee-for-service side that will flow through and determine whatever the cap rate is for M+C.

MR. HACKBARTH: On Alice's first point about the data lags, I could use some refresher on why this has been such an intractable problem and what would be necessary to get more up to date data. I know that came up yesterday when we were on --

MR. ASHBY: Why we're behind, in other words?

MR. HACKBARTH: Yes. But not just the temporary problem or the one that you hope is temporary, but the more chronic problem that we're always dealing with old data.

MR. ASHBY: Let me describe the steady state

situation first. That is that at the end of a hospital or any provider's cost reporting period there is a three-month period for which they are allowed to submit their cost report. Then this last year they moved that to four months because the program has gotten complicated enough that the providers couldn't get there any faster than that. So now we're four months past the end of the fiscal year and the hospital is just submitting the cost report.

Then there's a second factor that I'll throw in as long as you asked the question, and that is that when we say 2000 we really mean midway between 2000 and 2001. We have a very strange way of accounting for years that puts us a half a year behind what it even looks like. The reason why that's the case is because we're not talking about fiscal year 1999. We're talking about cost reporting periods starting in fiscal '99. You can just multiply that out. By the time you start at the tail end of '99, you're really most of the way into 2000.

DR. ROWE: That's good news, because that means that the data are six months less old than they look.

MR. ASHBY: That's right.

DR. ROWE: That's not bad news. That's good news.

MR. ASHBY: Let's take the positive spin. That's the truth. They are six months less old than they look.

DR. ROWE: It's how old are the data, and what you're saying is they're six months younger than they look.

MR. ASHBY: That's exactly right.

DR. NEWHOUSE: You should round up and not round down.

MR. ASHBY: Right.

DR. ROSS: Successful aging, as it were.

MR. DEBUSK: Jack, let me ask you, is it not true that we're talking about the cost reports. As I understand it, the hospitals are not getting the data they need from CMS to do the cost reports. So it's really the reverse.

MR. ASHBY: Right, that has been one of the -- we started out with generally steady state situation. Now in the current situation, right, one of the problems is that the FIs have been behind in submitting information back to the providers that describe their claim volume that they should use in filing their cost report. So until the FIs make the first move, providers can't make the second move, which is to submit a report on time. That's one of the things that has delayed matters here.

The other thing that has delayed -- and I'm not sure that I can really answer why the FIs are behind. There may be someone from CMS that can answer that. I don't really know. But the second thing that has delayed the process this year is the several policy changes that have gone into effect that have required changes to the cost report. They have even been more complicated than usual changes to the cost report because they have done in mid-year, which means they've got to have one variable to capture what's happening in the first half of the year and they've got to have another variable to capture what's happening in the second half of the year.

By the time they change the cost report and then that filters back to the accounting firms that create the automated packages for processing them so that they can be up to date, and then that gets to the provider and so forth, it just takes time for these changes to flow through. I really have to say in all honesty, I think HCFA was given some virtually impossible timelines for implementing some of these new provisions and actually getting them into the cost report.

DR. NEWHOUSE: But am I not right in remembering

that AHA put together a sample of several states that we were going to use for quicker data?

MR. ASHBY: That's the survey that we are, together with CMS are sponsoring, and AHA is carrying out. We have a sample of 500 hospitals that does have --

DR. NEWHOUSE: So how does that play into this timeline? Refresh my memory.

MR. ASHBY: That's what I was referring to a moment ago, that we really will have some 2001 data for a sample of 500 hospitals. The downside of that is that there is Medicare-specific information in that survey. It can tell you generally what's happening at the bottom line of hospitals and what's happening in terms of cost growth for all services and all payers. But we don't have Medicare-specific information.

DR. NEWHOUSE: Is there a way to patch into HCFA claims to try to get a rough read on what would be Medicare-specific -- I guess they don't know the non-Medicare specific. You'd have to have claims volume to the specific provider.

MR. ASHBY: Yes. But I do want to add one optimistic thing and that is that there is movement afoot to

make the short term survey specific to Medicare, in fact specific to all payers. That's being done through the AHA, a partnership with the Colorado Hospital Association that's putting this together. So we may actually, before the too distant future, reach a point where we can create a national aggregation that is specific to Medicare on a much shorter time turnaround. This is not going to happen tomorrow, but development is underway.

DR. ROSS: Just to respond to Joe, too. Again, in one of the boxes that Nancy showed up there in terms of the market factors, entry, exit, volume, unit cost, that's part of the exercise here is to look at all the sources of information you have available. But recognizing that the inferences you can draw get much weaker as soon as you get away from anything that's Medicare specific.

DR. NEWHOUSE: Where does auditing fit into it? Are we talking about the audited or unaudited cost reports on this timeline?

MR. ASHBY: We definitely use unaudited cost reports. Then the database is updated periodically when the audits come in. So we will have some combination of audited and unaudited data at most points in time.

DR. NEWHOUSE: Do we ever look back and make corrections for the audits?

MR. ASHBY: We always correct our stream of numbers every time we publish a new set. It's makes very marginal --

DR. NEWHOUSE: But I mean a lookback to the numbers that we used to do that incorporated the unaudited numbers. Do we ever look at how much error the unaudited number introduced?

MR. ASHBY: Yes, we have looked at them. But it's hard to isolate the effect of the audits because it's combined with trailer reporters as well. You'll go from 90 to 95 percent completeness at the same time as a bunch of audits are --

DR. NEWHOUSE: The same question. Do we look back at --

DR. ROWE: The same question. If you take all the adjustments, imperfections, improvements, et cetera, how much of a change does it make in the data?

MR. ASHBY: It's been known to change the margins by a couple of tenths or so after the fact.

MR. HACKBARTH: We probably should keep moving

ahead here and get on to the physician piece of this.

Kevin?

DR. HAYES: So we're ready now to take a step forward from the discussion that we just had and talk about applying MedPAC's model or approach, framework, whatever we want to call it, to payments for physician services.

Doing so seems particularly timely. I recall that the Commission is on record recommending that the current method for updating payments for physician services, the sustainable growth rate system, that that system should be replaced. So an obvious option here would be to replace it possibly with the update approach that the Commission uses. So what I'd like to do is just spend the next few minutes going over that and explaining what it would entail to do so.

I'm not going to spend a lot of time on the problems with the SGR system. We talked about them at the October meeting and so on. Just go through these quickly. We said --

MR. HACKBARTH: Kevin, I don't think that you need to review those. We've been over this ground.

DR. HAYES: Okay. Can I make one point though

about the last item having to do with volatility and unpredictability? At the October meeting we reported on an estimate that we had prepared of the update for 2002 and said that it would be in the neighborhood of a reduction in payments of 4.5 percent. Since the October meeting CMS has published the official update for 2002 and they said that it will be a reduction in payments of 5.4 percent. The difference has to do with some miscalculation of actual spending for physician services in years 1998, '99, and 2000. So that error needs to be corrected and the way to do that, according to the law, would be to take it out in the update for 2002.

Once again, just reaffirming the comment that we made last time about the inherent volatility and unpredictability in the system.

So what are the options for replacing the SGR system? One possibility would be to come up with an alternative, a spending control mechanism like the SGR system. And certainly there seems to be ways to reduce some of the volatility problem; a greater use of averages and so on in the system rather than the year to year changes in the factors that go into the calculations.

But that would leave the other problems that we see with the SGR system: its inability to account for shifts of services from inpatient to ambulatory care settings, for example. It just doesn't seem -- the path toward a different kind of spending control mechanism is not very clear; one that would correct the problems with the existing system.

So the other option then would be to do what the Commission is considering now, which is to focus update recommendations on payment adequacy and changes in input prices. That would seem to be a way to avoid problems that the SGR system has. It would allow for some discretion in the decisionmaking process, smooth out some of the volatility, take into account factors that are not accounted for now. And overall, just make the update mechanism for physician services similar to the mechanisms that we use for other types of services.

On the next slide we have a draft recommendation that would take us a step toward that second option of replacing the system with an approach that focuses on payment adequacy and changes in input prices. We show you this recommendation now -- we're not asking that you focus

on the wording of the recommendation. Certainly we have the December and January meetings to do things like voting and so on. But it was just our way of trying to drive home the point of what we're talking about here, of replacing the SGR system with this focus on payment adequacy, changes in input prices.

Our question for you today really is whether you see yourselves making this kind of a recommendation for the March 2002 report. And if so, what would it take to get us there.

If you are willing to consider that idea, then the question becomes, how is it that we would update payments for physician services using this approach? That would require, as Nancy and Jack said during the previous session, it would require answers to two questions. First would be, is the current level of payments too high or too low? Then secondly, what factors would we expect to affect the cost of providing services in the forthcoming year?

Just to further illustrate what we're talking about here, this is the same diagram that Nancy used. What I've done here is shaded in the one box on the upper left corner having to do with the question of whether payments

currently are too high or too low. What I'd like to do for the next few minutes is to just explain what it is that we have available to us in terms of information to answer that kind of question. So we'll proceed with that next.

The point to make here, I guess, just to reiterate what Nancy went over was that there are a variety of ways to try and answer a question, is the current level of payments adequate? We could, in some instances, use information on financial performance. We can look at things like access to care, entry and exit of providers, and so on.

As Nancy mentioned, we don't have information on anything like cost reports or other information that would be available to fully assess financial performance. As we indicated in the mailing materials for the meeting, there are some limited information available on that point, but it's not something that we could use for a more general type of analysis.

DR. NEWHOUSE: Kevin, can I ask a question on the first point? To what degree does that reflect the shift into managed care or into M+C?

DR. HAYES: The entry and exit you mean?

DR. NEWHOUSE: The growth from 13.9 to 15.7. In

other words, to what degree is that a function of changes in the denominator?

DR. HAYES: It is a definitely a function of the change, partly a function of change in the denominator, but also the numerator. There's a table -- I'm sorry, I only gave you counts of physicians here on Table 1 of the mailing materials. But you can see that there is an increase in the number of physicians. But at the same time, there is, of course, a reduction in the number of beneficiaries. So it's kind of a combined effect.

DR. ROWE: But I think Joe's question is, what about the M+C, migration out of M+C into --

DR. NEWHOUSE: No, the other way around.

DR. ROWE: There was no migration from Medicare to Medicare+Choice in this time. Didn't Medicare+Choice decline during this time?

DR. NEWHOUSE: No.

DR. REISCHAUER: It peaked in '98.

DR. ROSS: There's actually two ways to think about that ratio though, one of which is to treat it literally as entry and exit. Then the second is to ask availability of physicians per Medicare beneficiary. So the

answer is capacity would appear to have increased over that period.

DR. NEWHOUSE: No, not if they're servicing the M+C people also, and that isn't in here.

DR. ROSS: This is the number billing traditional Medicare, so the capacity to bill traditional Medicare has increased 10 percent over that period.

MR. MULLER: How do you exit a program that gives you half your business? I understand the numbers are going up, but the point is Medicare is so big that physicians and other providers tend not to exit because they walk away from half of their business. So the notion of exit here, it's not like restaurants exiting --

DR. ROWE: I think this is the same point Alan was making earlier when he said if you call and say, are you serving Medicare beneficiaries, the answer is yes. So the exit is artificial.

MR. HACKBARTH: So what we could say is that if you saw a significant decline in participation -- this would be a lagging indicator and probably an indicator of extreme distress is there was a big net downward move.

DR. ROSS: Not to be flippant, but you're only

going to get three data points, so don't throw this one out.

[Laughter.]

MS. ROSENBLATT: Can I just make a point on this issue because I think this may be one where looking at all physicians together may be misleading? I don't know, but I know that when we look at ratios like that we have to look at it by specialist and by area. Because in some areas we may pay lower, in other areas we may pay higher, similarly for specialists. The law of averages may in total make everything look fine, but when you look at the microcosm it's not fine at all.

I'd be very concerned about just having that Table 1 in our report without doing some finer level of analysis.

DR. ROWE: But isn't it true -- I mean, I remember years ago in this group whenever we were trying to increase the end-stage renal disease payments the point was always made by the economists that entry into the field was increasing, and more dialysis providers were signing up. Therefore, the payments were not inadequate. That was one of the big points. There was never this discussion about the finer grain analysis of where were they increasing, and how big were they, et cetera.

Isn't this a similar kind of piece of data?

MR. HACKBARTH: Entry is a little bit different than exit. For the reasons that Ralph mentions, exit is going to be the last resort. On the other hand, if you see significant new entry, I think you can say with a bit of confidence that the rates must be reasonable. It doesn't necessarily follow if there's no exit, the rates must be reasonable.

DR. REISCHAUER: But the relevant exit number really is how many new people are you willing to take on, because you aren't going to jettison your existing patient base probably. But an access problem could develop simply because every doctor decides, I'm going to take on half as many Medicare patients as I did the previous year.

MR. HACKBARTH: Fair enough. That's not the number that's up here. It's a gross number.

DR. REISCHAUER: That's why we're doing this --

MR. HACKBARTH: And for the reasons that Alan described this morning, trying to get the finer number of new patients is tricky at least.

DR. NELSON: There is one number that probably Kevin is getting to that I think may be more valid than most

of these, and that is the survey data showing that physicians by and large said they didn't have difficulty referring their patient to a consultant. I think that's maybe the most important piece of information we have. Are you getting to that, Kevin? I didn't mean to preempt you.

DR. HAYES: I was going to talk about survey data generally. I wasn't going to go into all the details. But maybe I should proceed in the interest of time and say that we talked about these entry and exit numbers. We have other information on access to care from the MCBS.

In looking at this slide I realize that we're pretty much overstating the case when we say no apparent problems with access in 1999. That is just based on the MCBS. It is a national survey. Of course there are going to be geographic areas where there might be access problems, but the MCBS is the type of survey that wouldn't do well in terms of picking up problems with that. It does, however, indicate that there are problems for certain vulnerable groups of beneficiaries, African-Americans, those with functional disabilities, and so on.

But in general, when we look at the data from the MCBS it looks like overall no obvious problems from one year

to the next; consistent trends with what we see in the MCBS data.

A physician survey that we conducted in 1999 showed that in general physicians were reporting that they were accepting new Medicare patients in that year. But there was a cautionary note that came out of the survey having to do with changes in physicians' practices. They reported that they were taking steps to reduce their costs, delaying purchases of capital equipment and the like. Similar types of things show up in other surveys of physicians.

The question here is, what does that mean, in the absence of any kind of quality information, information on patient outcomes, the kind of stuff you'd really want to know? We don't know what impact these changes in physicians' practices are having on the care that beneficiaries receive. So that's it for that.

So that's the state of play, to the extent we understand it in 1999. What do we know about events since then? There the information is quite a bit skimpier, if that's a good word to use. But we do know that we do have information, of course, on the payment updates under the SGR

system that have occurred in 2000 and that will continue -- did occur in 2001 and will occur in 2002. We can compare that to the change in input prices for physician services as measured by the Medicare economic index.

What we see is that the updates on average were 1.7 percent. The MEI showed changes in input prices of 2.4 percent. Recall that, as we discussed previously, the MEI is unlike other measures of input prices in that it includes a productivity adjustment. If we take that productivity adjustment out of the MEI we get a number like 3.6 percent per year in changes in input prices.

So from this kind of information, working forward from that 1999 reference point, we can see that in general the updates have not kept pace with the change in input prices.

DR. ROWE: Kevin, how does that relate to the fact that at the last meeting we were told that in part the reduction in 2002 was compensatory for overpayments in the previous two years in the physician update, in the SGR? Now you just said it hasn't kept pace with the MEI.

DR. HAYES: Right. It just has to do with the standard that you use. In this case we're just talking

about input prices, and updates being consistent with the change in the cost of providing physician services.

In the case of the -- I think you were asking why is it that there was a need for a reduction in payments in 2002? There the standard has to do with the target mechanism, the spending control mechanism that's used for -- in the SGR system the standard there is, is spending for physician service consistent with a target that's based on growth in the national economy? That's why this system is exacting this reduction next year.

DR. ROSS: Compensatory in the formulaic sense, not in the policy judgment sense; that's what you meant?

DR. ROWE: Compensatory is inconsistent with policy, right?

DR. HAYES: Just one more slide, if I may. So the question now becomes whether we can use information like that that I've just described to reach a conclusion about payment updates. If you believe that is so, you would be in a position for the March report to say something about payment adequacy in 2002 and that could be a foundation upon which to base an update recommendation, if you choose to make one, for 2003.

So you've got this reference point in 1999. You know what the payment updates have been like through 2002. We have information on these changes in physician practices; unclear exactly what it means, but we'd want to consider that I think in forming a judgment about what should happen in the future. I've got to say that there is some uncertainty, of course, about that 1999 reference point. We don't know really much about whether payments were too high or too low at that point in time. Just have the limited information that I went through.

So that's it. We can put the draft recommendation back up there, but just to bring home the point that from a staff standpoint at least we really need some guidance from you all about whether that kind of a recommendation captures your thoughts for the March report.

MR. HACKBARTH: Kevin, one issue about the MEI is the productivity adjustment there. I don't want to go into a substantive discussion of that right now, but is that something that we're going to be taking a look at between now and our March recommendation?

DR. HAYES: Yes, that would be a topic for the December meeting; the productivity adjustment, whether it

should be in the MEI or not, whether it should be based on -- whether it should be a labor only type of adjustment like the one we have now versus a multifactor adjustment of the type we use for other services.

DR. ROWE: My understanding is that we previously made this recommendation; is that not right?

DR. HAYES: We made part of this recommendation. You made part of this recommendation saying that the SGR system should be --

DR. ROWE: You're one of us, if you wish to be associated with us.

DR. HAYES: So the Commission did recommend that the sustainable growth rate system should be replaced. What we did not do was to go the next step and say what it should be replaced with. That's something we have an obligation to advise the Congress and one idea, what the staff is presenting to you today is the idea of replacing it with something that's anchored around the change in input price and then some assessment of payment adequacy.

DR. ROWE: Is it possible that we'll get more magnetism around this idea and more discussion of it as a viable option if we have a greater degree of specificity as

to exactly what we would propose as the alternative? We've come a little further now and we've identified some elements that would go into the equation. But if we were to actually come up with a specific, this is the MedPAC replacement for the SGR, then maybe that would help focus the discussion.

MR. HACKBARTH: Kevin, the way I look at the draft recommendation is you're basically saying, this is where we're going right now, and if you think we're going 180 degrees in the wrong direction, now is the time to say so. But we're not at a point where today we have to embrace this and say, this is MedPAC policy. There will be more specific discussion before we reach that point.

DR. HAYES: Right.

DR. ROWE: I guess my point -- Glenn, I appreciate that. Thank you. But what I'm trying to do is ask the question whether our advice to Kevin and his colleagues at this point is not just to go ahead and proceed along these lines but actually come up with a specific formulaic, to use a word Murray used, approach that we could consider, an actual formula.

MR. HACKBARTH: But it won't be formulaic. To me -- and correct me if I'm wrong, Murray -- but generally what

we're doing is moving away from the formulaic SGR to an approach that involves the exercise of judgment after considering a number of factors.

DR. NEWHOUSE: I thought that's what we had recommended. I thought not only said, we don't like SGR, but we should replace it with something that looks like the hospital update system. We never said that?

DR. ROSS: No, we --

DR. ROWE: But that's a formula. What he's saying is, it's kind of a balance scorecard where it's going to be qualitative and quantitative measures that are taken into account, or something along --

DR. ROSS: I would put it a little bit differently. What you recommended previously was doing away with the SGR -- silence. There was nothing said to put in its place. The obvious alternative to an automatic formula would be something formulaic or randomly chosen discretionary numbers. For staff, we figure that's pretty obviously where you're going.

The question for us is, what do you need to see to make you comfortable? In essence, you're going to be asked to make a judgment about what the conversion factor in 2003

should be. Because it's not just what's the update process. But if you move away from one system, what's the starting point for the new system.

So think about the task at hand, what should the conversion factor in 2003 be? What evidence do you need us to bring you to develop a comfort level to be to pluck that number, wherever those numbers come from?

DR. NELSON: I think we're going exactly in the right direction in having the recommendation that's based first on a reasonable assessment of the current adequacy of payments, and then secondly a combination of input prices that we have yet to define. But it seems to me that this is far superior to the SGR and the direction we should go.

Also the first part of that, the adequacy of payment should allow us to not always be three years behind. For us to propose to Congress some statement now on adequacy of payments when there were increases of 5 percent based on next year failing to accommodate the fact that we're going to have a drop in 5 percent, and then project for the following year. That's nonsense. I don't see how we can -- we'll have to just flip a coin in public.

MR. HACKBARTH: So, Kevin, are there now or will

there be changes in the survey cycle that we need for this analysis that will allow us to have more timely information on payment adequacy?

DR. HAYES: Yes. That could certainly be part of the package of recommendations that you adopt. If you agree that this kind of an approach makes sense, then we would need to decide on what needs to drive that process. Greater regularity of surveys would be one way to proceed.

The Medicare current beneficiary survey is already on an annual cycle. There are some lags in producing data from it, and so on. We've explored the possibility in the past of getting more rapid turnaround of the MCBS data and it just doesn't seem like that's possible. So we're always going to be looking at data that are a couple of years old with respect to the MCBS.

The physician surveys are a different story entirely. MedPAC's survey has been one that we've sponsored as the need arises. The alternative to that is a survey that the AMA has conducted in the past, the last one of those, the socioeconomic monitoring system survey I'm talking about, was fielded in 1999. My understanding is that they're now working to revive some variation of that

survey. But there again, we're looking at some lags in terms of availability of data.

So it would seem like from a physician survey standpoint the best source of information we have are the surveys that we do. We're able to get data out of those surveys within a few months after field work is completed. So that's what I know about surveys.

DR. REISCHAUER: Just briefly. When we do our discussion of the SGR and how terrible it is, I do hope that we make note of the fact that our idea for a replacement drops one of the objectives of this policy. Maybe it was an inappropriate one, but it was concerned about limiting the growth of overall cost to an affordable level. I think this was misguided but we can't pretend that we're geniuses for discovering a better way of doing half the job, because we really aren't doing the same thing.

The word adequacy, I'm wondering what's the meaning of that. If we thought of asking the question, what should the government pay for cans of soup, or lawyers' services, we wouldn't be going about doing it this way. We'd say, hey, there's a private market out there which sets a price. What do they pay for it? That's what we should

pay?

One alternative, of course, is to go to Janet and Alice and Jack and find out what they pay and then realize that they're paying a little bit too much because maybe we're paying a little bit too little and you could work out a formula for how it came out. That would be one definition of adequacy.

Another definition would be, we're a big purchaser. We're the 800-pound gorilla. What's the least we can get away with, recognizing that we're shifting the burden off onto some others but we're not going to focus any attention on that, and what we want to do is just skate along that edge.

What is it that we're trying to do?

DR. HAYES: Skate along the edge. You put it just right. Seriously, it's going to be a case where a judgment is going to be required, and it's going to be a matter of taking information from these disparate sources. As we indicated in the mailing materials, we are pursuing the feasibility of doing some comparisons of Medicare's payment rates with those in the private sector. So we can, not for this time around, but in the future we have some possibility

of being to add that to the mix of data sources that we can draw upon.

MS. BURKE: Can I just underscore Bob's point. I must say if we're going to use words like adequate in any kind of formulation in articulating what it is that we're trying to achieve, we'd better have a sense of what that means. I don't have any sense at all what adequate is supposed to be. Whether it's, their incomes ought to be X or -- I don't know what that means. But if it's going to be a term of art then we'd better have an agreed-upon definition.

DR. ROSS: In other chapters, the Commission has talked about paying the cost that efficient providers would incur. That's a fairly long-winded term. You might prefer payment appropriateness since it sounds less loaded. Again, that doesn't exactly trip off the tongue.

MS. BURKE: But I think back to the old days when we tried to do Boren rules and tried to live by language that none of us could define. That's what Boren got us into in the old days. So when we start using terms like that -- I mean, if we're all comfortable. But following up on Bob's point I just think if we're going to use it we ought to have

a sense of what it means.

DR. ROSS: Staff are open to suggestions there. I guess our view has been that there is a notion underlying this that we'd know the right payment if we saw it. The question is, is this a semantic issue or is it something else?

MS. ROSENBLATT: Just to follow up on the survey you just mentioned, Kevin. Where are these consultants going to get the data from?

DR. HAYES: The survey of physicians?

MS. ROSENBLATT: No, of how Medicare's payments compare to payments made by the private sector.

DR. HAYES: That's what the feasibility study is all about, is to, one, explain why it would be useful to do this kind of work. And two, to identify potential data sources that we could draw upon.

MS. ROSENBLATT: Let me just mention that we tried to do something like that and we went outside and needed to follow certain ways of doing it to satisfy our lawyers that we were doing everything okay. The outside people went to physicians' offices and tried to get information, even offered to pay, and they were unable to get anything at all.

The other thing I want to mention is that this is another area where looking at the totality does not give a good picture of the small piece. A lot of carriers do not use an RBRVS type mechanism. They use their own proprietary schedules. You could say for a given carrier that on the average it's X percent of RBRVS weighted by the relativities of services.

But when you actually look at it and you look at particular areas, and you look at particular specialties, one might 150 percent of RBRVS, the other one might be 50 percent of RBRVS. So I just caution us about, averages do not work here.

DR. HAYES: Right, I think we're aware of that. I think these are issues that will be addressed in the feasibility study, but your points are noted. Thank you.

DR. STOWERS: I'm just answering what Alan said earlier. A few years ago we did a study of physical medicine usage in Medicare, and we did it based on CPT codes. HCFA provided us less than one-year-old data of every CPT code broke down by specialty and the amount of usage by specialty. I'm wondering if something like that where it would be important to know if the specialty care is

still there and so forth, that we couldn't track that data. And they have that relatively quickly because -- so anyway, I could talk to you more and show you what we have.

DR. HAYES: Okay, that's good.

MR. HACKBARTH: Thank you, Kevin.

Sharon, home health.

MS. BEE: In my segment of this presentation -- and I'm not the last one -- I'll apply our payment adequacy framework to home health services. A quick refresher. In the past home health was paid on a cost-based basis. Last year in October we switched from that cost-based payment system to a prospective payment system. It's now been in place for a little over one year. In June of this year, CMS announced that they would implement the legislated update of marketbasket minus 1.1 for fiscal 2002. So that update was a positive 2.5.

The typical data cycle actually experienced minimal disturbance, given the potential disturbance of moving every provider in this system into a new payment system simultaneously. Despite that fact we will not have a measurement of cost or payments under the PPS system for some time. So my presentation today is going to focus on

some other parts of our framework that we can fill in.

This is the same model. What I've done is shown you in red where the information that I'm going to offer you fits into this payment adequacy framework. What I've got to present to you are market factors. I have some information on changes in product, beneficiary access to care, entry and exit of providers, and changes in volume.

As far as changes in product, what we did by going from the old system to the new system is change the way we measured the product. We used to consider the product to be a visit and now it's an episode. An episode is a 60-day unit of payment, and within that unit we can deliver a variable number of visits but it still has the same payment.

Regarding access to care what we found is that beneficiaries have good access to care. In a survey conducted by the Office of the Inspector General in April of this year, so six months into the new payment system, they found that most hospital discharge planners said they were able to place all of their beneficiaries with home care needs. Of those hospital discharge planners that could not place all of the beneficiaries, at most they could not place between 1 and 5 percent. Very few had problems with placing

more than 5 percent of the beneficiaries.

These results were essentially the same as those found in a similar survey in 1999 under the IPS. So what we believe is that access is about as good as it was at least under the IPS for context.

MR. FEEZOR: Sharon, was there a timeframe on the placement, within three days, within five days?

MS. BEE: Were able to place. Some discharge planners did note that for some beneficiaries with some conditions there might have been a delay. When MedPAC talked to hospital discharge planners we found that there were some delays, but they were getting access to home health care.

We have a little bit measure of access for you this year, I'm also happy to report. In the past we've been looking at access to care for those beneficiaries who have been discharged from a hospital. But in the year 2000, for example, we know that 38 percent of the beneficiaries in home health care did not come from a hospital or nursing home, they came straight from the community. What the Office of the Inspector General did this year was to try to get their hands around access from the community.

We think that beneficiaries coming from the community were especially prone, if we were going to have access problems, to experience those. They're going to have fewer resources. They don't have a discharge planner to make them aware of resources in their community, to explain the benefit, et cetera. We also think that beneficiaries coming from the community were more likely to have chronic conditions, and we thought that those people who were experiencing problems or delays were most likely those that had chronic conditions.

What the IG found though in trying to talk to a wide variety of people that would be working with beneficiaries coming from the community, they spoke with physicians, aging services representatives, and home health agencies. They also did this about six months into the PPS. They found that the strong majority of people they spoke to said that eligible beneficiaries referred from the community were able to get home health care.

We believe within our framework, therefore, that good access to care suggest that payments are not too low relative to costs. This measure cannot tell us, however, if payments are too high.

The other market condition that we have some information on is entry and exit. In the home health industry, we were talking about whether entry and exit really tells you very much. In 1997, there were over 10,000 home health agencies in the Medicare program. In the year 2000, there were 7,000. So we had a very rapid rate of exit from the Medicare program for home health agencies. From 2000 to 2001 though we went from 7,100 agencies to 6,900 agencies. So the rate of exit has significantly slowed.

We also found that the rate of entry has changed. In 1996, right before that ramp-up, we had 1,200 agencies enter the program. In the year 2001 we had 70. So we're seeing a decrease in exit, and we're seeing some entry but a significant slowing in the rate of entry as well.

Also to put this number in context, what entry and exit of home health agencies doesn't tell us is much about capacity. We know there's been merger and acquisition activity in the industry, so the number of agencies, we could have just a smaller number of larger agencies. It does tell us about the decision that providers are making to enter and exit but it doesn't tell us about capacity.

The fourth piece of information that I have to

bring you on market conditions is preliminary evidence on the use of the benefit. This preliminary evidence comes from a private firm that provides benchmarking analysis to private profit and not-for-profit home health agencies. They have about 700 clients that are geographically diverse but are probably larger and more sophisticated than the average Medicare agency. Their database contains over 150,000 patients. Staff would characterize these findings as findings as somewhat better than anecdote, but less reliable than scientifically drawn and analyzed sample of claims and agencies.

From this preliminary evidence we find that extra visits have not been added to avoid low-revenue episodes. Extra episodes don't appear to have been added to increase revenue. And that the length of stay continues to drop.

MS. BURKE: Just going back to the question between those two issues. The potential consolidation, or at least the decline in the actual number of home health agencies, can you track at that period of time the number of visits or encounters? Is there any way to look at whether in fact it's been a consolidation or an actual decline in access by looking at how many visits occurred and how many

people were seen during that period of time? Do you have any way to look at that data? It's a proxy for the number, but it would give you some sense as to whether we had a radical decline in the number of people actually being seen.

MS. BEE: Right. We have a decline in the number of users per beneficiary, so we know that fewer -- we have fewer home health users per Medicare beneficiary over that same period of time.

MS. BURKE: I'm not sure I understand what a user is in that context.

DR. REISCHAUER: What is the period of time?

MS. BEE: From 1997 to 2000.

MS. RAPHAEL: You're saying of the 40 million or so beneficiaries, a lower number are using --

MS. BEE: Using home health.

MS. BURKE: Was the reduction during that period of time consistent with the radical reduction in the number of providers? Did you see a sharp decline in users during the same period of time you saw a sharp decline in agencies?

MS. BEE: I really hesitate to make a correlation where I don't necessarily see a causation. We had a lot of other changes going on between '97 and '99. Importantly, we

had changes in the definition of the benefit. We had the elimination of venipuncture as a qualifying service. We had Operation Restore Trust which we think removed some fraudulent and abusive use.

So we would expect the number of users to fall over that time, and the number of agencies fell at the same time. But --

MS. BURKE: No way to connect the two. Okay, thanks.

MS. BEE: That's the kind of data that we have in home health. So those are the market factors that we have to work into our model.

There are two other issues in home health that fit into this explicit policy framework. Considering them in this framework is helpful because though they relate to payment adequacy, they don't necessarily relate to the relationship of total payments and costs. The two issues that I want to discuss are the 15 percent, which hasn't been implemented and relates to the appropriateness of current costs in our framework, and the 10 percent add-on payment for home health services in rural areas which has been implemented and is soon to expire and relates to the

distribution of costs.

DR. NELSON: May I ask a question? Before you leave the market factors, what kind of information do we have about home health providers who are running a negative margin but still in business? Because I didn't see that.

For example, a large integrated system that I know of, not-for-profit, is staying in the home health business despite the departure of the university and a for-profit firm, and despite losing $4 million a year on $17 million revenue, because they think it's important for somebody to provide home health services. So some idea of the number of home health entities that are losing money, but still in it, before we consider additional cuts I think is useful information.

MS. BEE: I don't know that I have the response that you're looking for. One of the problems that we have with the data is that the most recent payment and cost that we can get for home health are going to be for 1999, which is before we even implemented the PPS. So I could tell you the margins in 1999, but that doesn't tell you very much about the margins for the providers that are still in the system, and it doesn't really tell you very much about

whether our new payment system is adequate, inadequate, too high, too low.

MR. MULLER: Glenn, this is the third time this has come up. I think we've got to get rid of that word current. It's lag or it's old, but it's not current. I mean, I understand the problems of the surveys, Alice's question and so forth, and everybody's comments have made. But to have three-year-old information and call that current is just a misnomer. We should point out there's many reasons why that's the best we have. But to call that current implies something that it's not. So we can call it something else; three-year-old current data.

But basically what I referred to earlier as the black box -- I mean, part of the discussion that we heard this morning where there was quite a bit more of more heat in this, whether it was around blood or around devices and so forth, are around people's conjecturing about which way the vector is going. There's a lot of difference of opinion which is high to refine as to whether it's sloped this way or that way or that way or down that way.

Since we're obviously in an imperfect art where we have three-year-old data, the survey and sampling

methodology which we'd like to have is difficult to implement, though certainly I am very much in favor of a lot of work on that to get the data a little bit more current through surveys and sampling. But both the loaded word of adequacy and the word current I just think is a misuse on three-year-old data, so I would urge us to be careful about using that.

At the same time, I understand those ratios are being used and applied to current payment numbers. So a lot of the question is, how much has the world changed in those last three years that is different than what the ratio was in '99? But now I've seen it three times where I just want to say I don't like the word current there.

MS. RAPHAEL: Glenn, can I just comment on this? First of all, I think that there may be a slowing in providers leaving but there's a change in the distribution of providers. The providers who are most likely to have left have been the hospital-based agencies, because the prospective payment system had the greatest effect on them, and they benefited to some extent from a cost-based system for a variety of reasons.

So I think that it is important as we look at the

market to understand how providers are shifting. There is another variable that's coming into play which I don't know how you factor it in but at least it's creating static. I know we have 20 percent more demand than I have supply right now, and I have a lot of elasticity, but it's constrained by labor market shortages. So that I think that really is affecting access. I think you're right, Sharon, that it doesn't have to do with "payment adequacy" but it really has to do with other factors in the marketplace that we just need to be cognizant of.

MR. HACKBARTH: There are a host of problems with the data. Timeliness and whether the surveys are couched just right and answering the questions we want to answer. Two reactions to that. One is, this is the world in which we live. We really don't have any alternative but to make decisions in the face of great uncertainty. That's not new as a result of this reconceptualization we're going through. That's the world that we've been in all along. So we have to be careful not to attach it to these frameworks.

Second is that there is a default in each of these cases, and the default is our measure of input price change. So we're looking at these other data to say, is there

something there that we find sufficiently credible to depart from the default, either up or down? Again, that's not really any different from the old world that we were in either.

So it's frustrating, and over time hopefully we'll get some better data on some of these things, but it's something we've got to deal with. It's not Sharon's fault.

MR. MULLER: I fully concede that that's the world we were in before. We're just using new terms now in ways that I just have some discomfort with. I'm quite willing to concede that making these calculations is a difficult process.

I would also point out independent of this that no matter what we say there are other kind of considerations, such as where they arbitrarily do things where they lop off percentages or define what productivity is and so forth. So there's a lot of subjectivity that comes in the process at the end. I'm just saying we shouldn't have false precision in a process that has as many difficulties as this has.

DR. ROSS: That's in part why we presented that cone earlier which is, these boxes you've seen up here that say the word current are sort of the wish list and then

there's the reality.

MR. HACKBARTH: What we bring to this whole process is that hopefully we will probe and search and push trying to find the best possible information to make what is a very difficult decision. There may be other participants in the process who don't have the time, the resources, the inclination to do that, so persist we must.

MR. MULLER: Could I make just one last point on this? Given the discussion we've had in this and some other sessions as well about the under-funding of CMS and so forth, and what might be, I don't want to call it a trivial amount of money, but the lesser amount of money it might cost to invest in some of these processes, when you think about the debates we have here, whether it should be one whole percentage point of update is billions of dollars. For far less than billions of dollars one could deal with some of these issues.

Therefore, this is just one more example of when one is dealing with three-year-old data and all the kinds of difficulties one has in updating that and so forth, some investment in the appropriate funding of CMS and other governmental agencies, whether it's this morning's

discussion of quality and putting money -- obviously there's been some money put into AHRQ in the last year or so. But this does beg for a little bit more current information, and I think some of this would be fruitful for us to be I think a little bit, at the right time, a little more vociferous on that. Others could help us on some of these other kinds of issues as well.

MS. BEE: We did actually, in June of this year, also make one recommendation that speaks to that. For home health cost reports we suggested that CMS be given the resources to do a sample of cost reports. So that might -- rather than waiting to pull all the information together, audit it and give us something that we can use, to maybe decrease the time a bit.

MR. HACKBARTH: I would welcome some discussion of whether we ought to include in this report where we talk about this new approach saying, by category, here's a specific recommendation on what sort of data that we think ought to replace the flawed data that we've got. The more specific, the more concrete we could be in a recommendation request about that, the happier I would be.

The one thing that I hate is just sitting here

lamenting the fact that the data are poor. If we've got an idea about what we need, let's articulate it and argue for it.

DR. NELSON: We keep griping because all we've got is claims data or data that CMS has. What I'm saying is a random sample of well-run agencies and 20 telephone calls asking them whether they're losing money and how much, what their last year's filings look like. I made that kind of a phone call. And it's true that it's an anecdote, but if I call a well-run outfit and find out that they're losing a dollar on every four in revenue, that means something to me.

DR. ROSS: Just one thing on surveys because we actually have over the past couple years undertaken a number of different efforts. It's not just a matter of giving a couple hundred million or a billion dollars to CMS. It's getting people out there in the private sector, and then to respond both appropriately and accurately and being willing to do so. There are so many surveys floating around out there now that the willingness to participate on a voluntary basis, and the likelihood that you're going to get the accurate information that you want with no money attached to it, they're both pretty low.

There's a systemic problem here, that I agree with Ralph, that it would be nice to address. But it's not just do more surveys, because we've been trying that and that doesn't work.

MR. HACKBARTH: Sorry, Sharon, we got off on a bit of a tangent.

MS. BEE: The good news is that we have two decisions at least, or points in our framework, that if we choose to weigh in on them probably require less than laser precision. The first one is the so-called 15 percent cut. This cut was originally legislated as a contingency in the Balanced Budget Act of 1997. In that environment of high and increasing home health spending, the costs were judged to be too high.

So the BBA set forth an outline for IPS and PPS and had a contingency that if the PPS for home health was not implemented by October of 2000 then the cost limits of the interim payment system would be lowered by 15 percent. When the PPS seemed to be running on schedule, the legislation was modified. The PPS rates would be set so that the new system would not only be budget neutral to IPS but also incorporated what we would have saved from the 15

percent trim. That new version of the reduction was then postponed. So then what we have is currently scheduled for October 2002.

The key to understanding this 15 percent cut is the baseline. If implemented, the law would not require a 15 percent cut in current spending. Instead it seeks to set spending now equal to what it would have reached had the IPS limits been reduced 15 percent. The wrinkle is that that hypothetical level would be a projection, and the analysts at CMS know that if IPS rates were cut 15 percent it would not result in 15 percent less spending. The providers would respond to the reduction in rates presumably by increasing volume.

So what I'd like to do is just put a quick sketch. This is intended to illustrate the effect of implementing the 15 percent cut. The top line is spending under the IPS. Since the PPS is set budget neutral to that, that's also the PPS spending.

DR. NEWHOUSE: What's our basis for this estimate?

MS. BEE: This is an estimate. It's just a sketch. I do not presume to attach any numbers to the spending line.

DR. NEWHOUSE: So you don't rule out that the number could be zero.

MS. BEE: The spending?

DR. NEWHOUSE: No, the offset effect.

MS. BEE: That's absolutely possible.

MR. MULLER: So why would you do that?

MS. BEE: Because we believe that that's how it's going to be modeled by CMS.

MR. MULLER: In the absence of data?

MS. BEE: CMS is required to compute the spending level that we would have reached had we implemented the 15 percent reduction in the IPS limits based on the most recent available cost report data.

DR. NEWHOUSE: But the only mechanism for doing this is to have additional low cost episodes, and there's incentives to do that as it is. In fact quite strong incentives. So I'm not quite clear why we think the home health agency would suddenly tumble to this idea if we implemented a 6 percent cut.

But let me ask a question. Will we have numbers when we face this decision similar to what Kevin showed us on input prices? It seems to me that would be helpful.

MS. BEE: CMS will try to produce this number as soon as they have the 1999 cost report data to model it on.

DR. NEWHOUSE: No, not 1999. Don't we have an input price index for home health agencies that we can make more current than 1999?

MS. BEE: We have a marketbasket for home health.

DR. ROSS: But the bundle changed since 1999. We went to a 60-day episode. That's the new --

DR. NEWHOUSE: No, I'm not talking about what we paid. I'm talking about getting an input price index.

DR. ROSS: I'm not sure where you're going with this, but we have a marketbasket.

MS. BEE: I didn't mean to divert the discussion. The purpose of presenting the sketch was merely to illustrate that though this policy is called the 15 percent cut, its real effect is probably between 6 and 8 percent decrease in the PPS base rate.

MS. RAPHAEL: When we have to make this decision, how do you see us going about determining whether or not this is a good move or a terrible move?

MS. BEE: What I would suggest is that since the initial conception of the 15 percent cut was made, which was

based on the assumption that costs were not appropriate. They were based on the assumption that costs were too high. Since the conception of the reduction spending for home health has dropped considerably. The ratio of users to beneficiaries has dropped, and the amount of use per user has fallen as well.

Also, the incentives of the system have changed. Under the cost-based system agencies had an incentive to provide more visits to increase their revenue. That system probably generated more costs than were strictly appropriate. Under the current system providers have the incentive to provide the lowest efficient number of visits per episode.

DR. NEWHOUSE: How did efficient sneak in there? How do we know it's just not lowest?

MS. BEE: We are measuring their outcomes, so we have a means by which we hope to be able to detect stinting.

MS. RAPHAEL: Who are we? Who is measuring their outcomes?

MS. BEE: CMS.

MS. RAPHAEL: I don't think so. I mean, they're getting a lot of data, but I think the fact that they're a

repository for huge data dumps doesn't mean that they're really measuring outcomes.

MR. MULLER: In many ways they're just satisfied with the fact that use went down, right? They achieved their aim.

MS. BEE: In large part.

MR. MULLER: So that's the outcome they wanted.

DR. NEWHOUSE: The they here was the Congress.

MS. BEE: Right, we have a couple of they's.

MR. HACKBARTH: I think we're at the point of diminishing returns on this. Important issues are being raised right now but they're not issues that we need to resolve right now. So what I'd like to do is move as quickly as possible to the end of home health so we can get SNFs in before we wrap it up for today.

MS. BEE: Another imminent policy issue is the 10 percent payment add-on for rural home health services. In the payment adequacy framework this fits in as a distributional issue. The Commission considered rural home health in some depth in June. This too is imminent but not immediate. It is scheduled to expire April 2003.

We have no evidence on this question either to

suggest that rural home health agencies are being affected differently by the PPS. We have some reasons to suspect that they might be. That's how that issue would fit into the payment adequacy framework.

Staff seeks the Commission's input on several aspects of the home health material from this meeting. Is the information we've provided helpful to make an assessment of payment adequacy? We would welcome any reactions -- we've had quite a few -- on the two interim questions.

Finally, we bring your attention to the OASIS materials in your packet. We've outlined some ideas for developing recommendations. Staff at this point wishes to ask the commissioners, do you wish to consider the issue? I believe we could contribute to the debate on OASIS with a recommendation to decrease two of the dimensions of effort in data collection. So we ask you at this point, would you like to see recommendations on OASIS that are more specific than the principle we recommended in June on data collection more generally?

DR. ROSS: How about I propose, if there's a lot of interest you send me an e-mail and we'll bring you something in December?

MR. HACKBARTH: Is that okay? I just don't want to open a whole new subject matter right now.

Thanks for bearing with us, Sharon.

Deborah?

MS. WALTER: This presentation will apply MedPAC's policy framework to address payment adequacy for SNF services.

The first step is measuring current Medicare payments and costs in order to document where we are at the beginning of the process. We're going to use fiscal year '99 margin data to provide us with this information. We will then to the relationship of payments to costs, and today I'm going to focus on two market factors including beneficiary access to care, and entry and exit of providers to hopefully provide some clue as to whether the payments are appropriate relative to costs.

The backdrop of our discussion today really needs to be considered in the context of some fairly significant but temporary increases to SNF federal payment rates. I should note here that these increases are in addition to the SNFs annual payment update.

Since a SNF PPS was implemented in July of '98 the

Congress has temporarily increased SNF payment rates in response to provider concerns, and collectively these increases are going to raise Medicare payments by about 28 percent, or about $2.5 billion. You can see them up on the screen. I won't go through them, but it is important to note that the first two increases that you see there are scheduled to be discontinued by the end of fiscal year 2002.

The Medicare margin is an important measure on the adequacy of Medicare payments to SNFs. This margin compares the payments received from Medicare for SNF services with the Medicare costs for these services. I think in setting up this discussion here it's important to remind ourselves that first what you see on the screen, these Medicare margins do not reflect the payment add-ons that I just talked about.

And second, that the Medicare margin presented here only includes freestanding facilities. You'll recall in our 2001 March report that we looked at hospital-based margins and we saw that after declining for several years, in 1999 the hospital-based margins reached an all-time low of negative 51 percent. By way of context, in this slide we see that Medicare margins for freestanding SNFs in 1999 was

9 percent. In the prior year to PPS the freestanding SNF margin was negative 2.4 percent rising to 0.3 percent in '98, which was the first year of PPS.

I think that there are a few points that need to be addressed to better interpret what this may mean. That approximately these numbers that you're seeing here, one-quarter of the freestanding SNFs in our sample were subject to PPS in July while the remaining 75 percent of SNFs did not come under PPS until January or later in '99. This surely contributes to the difference between those '98 and '99 figures.

Also that the '99 margin reflects the 75/25 percent blend of a facility-specific rate which reflects the individual facility's historical cost experience and the federal rate. This has implications for the work yet to be done and I will address this more at the end of the presentation.

I wanted to bring your attention to the urban and the rural margins. As you can see, they have steadily increased over time, reaching their highest level in '99 at 9.5 percent and 6.6 percent, respectively. As with hospitals, urban SNFs had consistently higher Medicare

margins than those rural SNFs, most likely due to the more expensive therapy services and other higher-priced services, combined with less availability for these services in the more remote areas.

Again, I think that I want to bring your attention to a really striking difference between, or among the not-for-profit, the profit, and the government SNFs. Government-owned SNFs have had consistently lower margins compared to the other two facility types between '96 and '99.

I think that it's equally notable that more than 11 percentage point difference in the '99 margin between the not-for-profit facilities and for-profit facilities. You can see the difference in '99 of 0.3 versus almost 12 percent. A larger ratio of staff to patients in not-for-profit facilities compared to the for-profit facilities likely account for this disparity.

DR. NEWHOUSE: What went on with the governments? They just tanked in '99.

MS. WALTER: They did. The best we can figure is they've always been less efficient. Certainly before PPS they were at least getting some of those costs recovered

because there were some exceptions, obviously, to the routine cost limit. They just, frankly, take the patients that absolutely nobody else wants. So under PPS we believe that they just -- they're just suffering.

DR. NEWHOUSE: It's important to try to distinguish those explanations.

MS. RAPHAEL: Can you give us the percentages also? What percent of the SNFs are government?

MS. WALTER: It's in the paper. Government is a very small percentage. It's like 210 facilities out of 14,000. These are the very old buildings that -- these are just like the old, old nursing homes that were in -- and Carol may be able to --

MS. BURKE: Are they county and state run primarily?

MS. RAPHAEL: They're county run.

MS. WALTER: All I know is that they're just the ones that take the patients that nobody else is going to take. That's my understanding. And they've always been very inefficient.

MR. MULLER: Some of the old mental hospitals would be classified as ICFs.

DR. NEWHOUSE: These are Medicare.

MS. WALTER: Yes, these would not include the ICFMRs.

As the PPS margins rose, you can see that the number of freestanding SNFs with negative margins fell each year from '97 through '99. But even in '99 we see that one in three SNFs lost money on Medicare SNF services. Although it's not shown on this slide, three-quarters of government SNFs, half of not-for-profits, and 39 percent of for-profits had negative margins. And a little over one-third of both the urban and rural SNFs similarly showed negative margins.

To assess whether the payments are appropriate relative to costs we also examined beneficiary access to SNF care, and provider entry and exit. With respect to the access issue, a series of early studies completed before the temporary increases did not find any widespread access problems to SNFs.

A more recent study reexamining this issue after the increases in BBRA went into effect but well before the 16.6 percent increase in the nursing component base went into effect, has similarly concluded that most Medicare beneficiaries have access to SNFs, although select groups of

patients with certain medical conditions or service needs continue to experience delayed entry into SNFs. These groups include patients who need IV antibiotics or expensive drugs, the ventilator-dependent patients, or those who require dialysis.

But I do want to add that when MedPAC looked at a lot of these different kinds of patient groups with the other conditions that were noted in the OIG and the GAO reports, we found that each of these really difficult, medically complex kinds of patients, each accounted for less than 1 percent of all SNF beneficiaries between '95 and '99. So in essence we're talking about a very small percentage.

With respect to provider entry and exit, following a large increase between '95 and '98, which again was the first year of PPS, the number of SNFs decreased between '98 and 2001. Most notable is the 19 percent decline, or 411 facilities in the hospital-based SNFs since '98 compared to the 1 percent increase, or 131 facilities in the freestanding SNFs during the same time period. We see that the largest drop occurred for those SNFs serving only Medicare patients; negative 32 percent in the case of hospital-based facilities and negative 6 percent in

freestanding facilities.

Based on the evidence presented today, we believe that payments will significantly exceed costs for freestanding SNFs between 2000 and 2002 resulting from the temporary legislative add-ons. We also believe that beneficiary access to care is not in jeopardy, nor does provider exit from the Medicare program seem to an issue for the freestanding SNFs.

Now on the hospital-based SNFs the story is quite different. The decrease in the number of hospital-based facilities combined with the previously reported negative 51 percent margin I think is just so much more difficult to interpret. We know that certainly some of what we're seeing has resulted from cost shifting and there was some advantages -- that the hospitals were taking advantage of that cost-based system.

We also know that hospital-based have a different staff mix; certainly more nurses, resulting in higher costs. Then there's the issue of the cost of the staff. Hospitals, most likely, cannot pay nurses in a SNF differently than they can pay in a hospital, and they can't have different benefits either. All of these are contributing, we believe,

obviously, to that lower margin.

We also know from our previous work that hospital-based SNFs serve a much more clinically acute population than do freestanding SNFs. As you recall in our March 2001 report, MedPAC found that the hospital-based case mix was 11 points higher than in freestanding SNFs. I guess I also have to say here that I think that some of what we're seeing are differences, and some of the differences simply are that the RUG may just not be accounting for the differences in the case mix.

A new classification may solve some of these problems, but it will not be until 2006 at the earliest. The question is whether Medicare wants to pay for the higher costs in hospital-based SNFs until there is a new classification system, assuming that there may be one. Otherwise, more hospital-based SNFs may be getting out of the Medicare business.

This becomes particularly important given that the SNF payments relative to costs will increase dramatically for fiscal year 2001 and 2002 due to these temporary add-ons. But once these add-ons expire, at least those two in fiscal year 2002, it will drop the payments back down so

that we believe that by 2003 the payments are going to look much like what we've been seeing for '99.

So thinking within the context of our policy model, the implications based on the evidence presented thus far raises some potential policy questions that the Commission should begin thinking about. Obviously it's difficult to respond to these questions until additional data are presented in December but I think that we can begin to ask ourselves, should the temporary payment add-ons enacted in BBRA and BIPA be allowed to sunset, or should they be phased out more gradually? Should the freestanding and hospital-based SNFs have a different base, or is market adjustment needed?

Now as I indicated early in my presentation, the 1999 margin reflects the 75/25 percent blend of the facility-specific and the federal rate. It could be argued that as more SNF providers are subject to the full federal rate the Medicare margin may look quite different. So in December what we propose is to present the data which model payments and costs based on the same sample using solely fiscal year '99 federal rates.

Additionally, we are proposing to model the 20

percent and the 6.7 percent increase to the fiscal year '99 rates to determine the potential impact on provider margins as the first two add-ons sunset in 2003, or at the end of fiscal year 2002. Staff will also continue to assess the financial performance of SNFs by comparing costs among SNFs that have exited the program with the SNFs that have not. And finally, we'll update data -- hopefully we'll have the data available to update you with on fiscal year 2000 on the spending and beneficiary use.

MR. HACKBARTH: Thank you, Deborah. Given the late hour what I'd like to do is defer any discussion of the issues right now. We will take this up again in December, hopefully with a little bit more information than we have right now.

So what I'd like to do is go ahead and move on to the public comment period. I apologize, Deborah, for being at the end of a long, long queue.

MS. WALTER: That's fine. The only question that I really -- if I may ask, is that in terms of the potential policy questions that we're posing, does the Commission generally think that we're going -- those are the right kinds of questions to ask? With a nod, I'm happy and will

walk away.

MR. HACKBARTH: Yes, I thought you did a good job.

DR. REISCHAUER: On the next steps, if we think it's appropriate to continue -- more money is necessary to continue what we've been doing in the past, or is there a better way to allocate this slug of money that would be more efficient or better? I would just add that as one of the alternatives.

MR. FEEZOR: The other thing that I think is so very, very critical in the SNFs is not just the general capacity but back to where Alice was talking about, where that capacity is will be very, very important. That wasn't immediately evident in the data but I think we need to keep that in mind as we evaluate some of the other policy options.

MS. WALTER: Capacity in what way?

MR. FEEZOR: Where it's located. Distribution, if you will.

MR. HACKBARTH: Thank you. Public comments?

MR. ELLSWORTH: My name is Brian Ellsworth. I'm with the American Hospital Association. Recognizing the lateness of the hour, I will be extremely brief. Just some

comments about the SNF.

I believe from MedPAC data from last year that hospital-based margins for SNFs in 1999 was something like minus 51 percent. It's really an astoundingly large number. As we phase into full PPS that would get worse because of that, and then the add-ons offset that only to a partial degree.

I guess there's two comments I would make in evaluating this data. One is with respect to case mix, is recognizing that the RUG system is in fact an imperfect measure of medical complexity. The weights are very compressed. So the data that was presented that the case mix difference is 11 percent, it's actually probably significantly higher than that between -- the difference between a hospital-based facilities case mix and all SNFs, because the weights that you're measuring with are very compressed.

The evidence I would point to on that is the refinement proposal that CMS made last year where they proposed refinements to the system that were significantly more stretched out than the current weights are. So you've got an imperfect measure of case mix there, which is one

thing to factor in.

The other, in terms of looking at cost, is the length of stay, the average Medicare length of stay for a hospital-based SNF is about 15 days. The average overall length of stay for all Medicare SNFs is about 30 days. So just as a very crude measure of outcome, for a more medically complex caseload we are achieving at least the outcome of discharge in half the time. That presumably mitigates our ability to spread fixed costs, and it's also presumably due to the increased medical presence that Deborah alluded to.

So I just throw that out there as an additional factor to evaluate when you're looking at a per diem system, recognizing that the overall costs on looking at it on an episode basis, that high per-day costs may be a bargain if you are achieving the outcome in half the amount of time.

Thank you.

MR. CANDER: My name is Mark Cander. I'm with the American Speech, Language, Hearing Association. We represent speech language pathologists and audiologists. We thought that the Commission should just know about something that happened regarding outpatient prospective payment and

cochlear implants.

Cochlear implants are something inserted inside the ear which the profoundly deaf persons cannot have any correction to their hearing except through this kind of mechanism. It's just curious that HCFA in the beginning of 2001 established the cochlear device as a pass-through device, but then later on in the proposed regulations that came out the end of the summer decided it was not a pass-through device.

The dollar amount that the Rand Corporation has determined is an average payment by hospitals is just under $21,000. The surgical cost for -- I'll just reference this as APC 259. The surgical cost by CPT code, about $5,500. The total amount that was proposed for 2002 is $15,500 total. So you can see that there's about a $10,000 shortfall.

We know that hospitals that do the cochlear implant often decide that they want to do it because it's prestigious to do it, it helps the community, but they know they're losing money every time they do the procedure. There have been hospitals recently that have dropped out and are not performing this any more. So I just wanted to bring

that to your attention.

MS. JOHNSON: My name is Pam Johnson. I'm with the American Society of Cataract and Refractive Surgery. I'd like to comment regarding physician services regarding problems with using the 1999 data as a reference point for looking at access to care. For physicians who saw a reduction in reimbursement for services due to the implementation of the practice expense RVUs, 1999 represents only 25 percent of the new RVUs. Specifically for cataract surgeons this was a 28 percent decrease.

Also regarding access to care, we're seeing many of our members, surgeons shifting their practice, going primarily from cataract surgery to refractive surgery since they have that option. So that's another area where we're seeing problems with access to care.

MR. MAY: Don May from the American Hospital Association. Appreciate the chance to comment at such a late hour. I just have three points.

First on blood, just a couple clarifications on the data that we gave to MedPAC staff. This is one of those things where the averages seem to mask a lot of what's underlying in the data. There are a couple issues. One is

our survey tried to capture information on the calendar year, which spread the impact of the decision of the American Red Cross to increase prices on July 1st only on half of the year. But remember, beginning with the federal fiscal year beginning in October that full increase goes through all of fiscal year 2002. So rather than being more like a 20 or 26 percent increase, it really is more reflective of that 35 percent increase that we hear hospitals talking about quite often.

The other thing about that is, for those hospitals that were previously not purchasing blood that was leukocyte reduced, they not only saw a price increase in the price of leuko-reduced blood. They had to go from buying non-leuko-reduced blood to buying a much higher product of leuko-reduced blood. So for them, it was not just a 35 percent increase, it was an increase in the total product they had to buy.

Lastly, I know Dr. Loop talked an awful lot about how this affects a major trauma center and surgery -- a hospital that does a lot of surgeries. But we've heard a great deal from rural hospitals as well who are really facing tremendous pressures from blood costs, even though

they're just your typical rural hospital doing what rural hospitals do, and not doing those major traumas and surgeries of the major teaching hospitals. So on that note, I just wanted to clarify our survey.

On outpatient, hope you all got a copy of the letter that we distributed. It's a very important issue to us and we appreciate you taking a look at the outpatient PPS system and evaluating it.

The last note is on the payment adequacy discussion. Again would caution looking at a target range margin. That target margin in aggregate, as if the whole country was one big hospitals, masks a lot of underlying differences and problems. We've got 34, I believe -- more than 30 percent of hospitals losing money on inpatient PPS for Medicare. We've got more than a third of hospitals losing money in total. And we've got 60 percent of hospitals approximately losing money on all their Medicare services.

So looking at an aggregate margins for hospital that is positive really masks a lot of that underlying inadequacy of payment. We all know that there's lots of ways that you can get a positive margin. Many hospitals are

efficient and they run at an efficient level and get a positive margin. But there are also hospitals who really feel the payment constraints that different payment cuts under the BBA or private payer and managed care put on hospitals.

There are other ways of getting a positive margin that aren't so healthy that hospital managers often feel they have to do to maintain their sustainability. But that does not allow them to engage in -- and improve their plant and improve their operations with capital investment.

The last thing -- and I think the discussion today on blood and on the outpatient pass-through, the whole issue of technology, really brings out the importance of talking and continuing to look at science and technological advances. And not just when we can identify that there's going to be a huge increase. Everything adds up. The impact of blood, even if it is only 0.1 on the marketbasket. You've got that plus you've got new devices, and you've other drugs, and you've got workforce shortages.

All of those combined add a lot of costs that aren't captured in the update. I fear that going to a payment adequacy model that doesn't maintain that, and that

automatically assumes that these things will be offset by productivity, really misses a lot of the pressure that hospitals are under today. So would just ask you to consider that as you go into December and start talking about the update for hospitals.

Again, appreciate the opportunity to comment today. Thank you.

MS. MCELRATH: I'm Sharon McElrath with the AMA. I just want to underscore something that Pam said about the fact that there have been a lot of changes in the physician payment system since 1999, and that's not necessarily a good year to start looking at the data.

The other thing is, as Alice mentioned, it will have affected different specialties differently, so you really need to get below the aggregate level.

Also it has affected different areas differently. I know, for instance, that the numbers from Colorado -- when you're looking at the '99 data that Kevin was talking about Colorado looks pretty good. It looks like they are way above the national average in terms of the number of physicians per thousand beneficiaries. But when you read the newspapers, there are lots of stories about problems in

Denver, and people who have been out there think that they are real. So there's something else going on there.

One other point. When you're talking about entry -- I agree with the point that was made that it's harder for a physician to exit. When you're talking about entry, I think you need to think about a lag time possibly, because the training pipeline is there. You've got these people who are coming out. They have to go somewhere.

On the MEI, certainly we'd be very happy to have you look at the productivity factor. We believe that does need to be changed. There may be some other things that you might want to look at.

Getting into the whole technology argument that people had here today, we think that one of the things that is -- and we don't have enough data ourselves to know how much it contributed, but the way that -- in the SGR and in the MEI, it's not clear that new drugs are actually ever recognized in there. Certainly in the SGR it all goes into a pool called other and it is given the same increase as the lab fees, which was zero. We know that a large part of the increase in expenditures in 2000 had to do with a lot of new chemotherapy drugs, many of which were introduced since

1998.

So it's not simply this business about the AWP and whether it's price. It's actually an increase in use in things that are going over and being used in different kinds of cancers. It's not clear to us that that's picked up anywhere in our system.

MR. HACKBARTH: Okay. Thank you all. We'll reconvene at 9:00 tomorrow.

[Whereupon, at 6:15 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, November 16, 2001.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, November 16, 2001
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Would everyone please take their seats?

DR. KAPLAN: Good morning. In BIPA, the Congress mandated that MedPAC study beneficiaries' access to hospice. The mandate language is on the screen and in your handouts. As you can see, the Congress is particularly interested in short stays and differences in rural and urban beneficiaries' access to hospice. We contracted with Chris Hogan and with Jay Mahoney to research these issues. After they present their findings and you've had an opportunity to discuss them with them Kevin and I will return to discuss next steps with you.

DR. HAYES: First we'll have a presentation by Chris Hogan on access to hospice care in rural areas. Many of you now Chris already. He was an analyst at PPRC and later at MedPAC. He's now the president of Direct Research, LLC.

DR. HOGAN: I used to work for this organization and one of its predecessors for many years and now I'm an independent consultant. I'm an economist, and I'm going to talk about a short study that I did on your behalf on access

to hospice care.

First I'm going to tell you why I'm sitting here, and how I came to be producing this report on your behalf. Then I'm going to talk about some recent trends in hospice to try and capture the growth and change in the hospice industry in the 1990s. Next I'll look at short hospice stays using about 600 hospice-using decedents from the Medicare current beneficiary survey. So it's a small sample but it's the best I could do with the available data. I'll look at urban-rural differences, geographically-based differences in hospice use and then I'll give you some conclusions.

In terms of the background, this report is really a spinoff from an AHRQ grant that was made to the then-George Washington University Center to Improve Care of the Dying, now the Rand Center to Improve Care of the Dying. We brokered a deal: that we would get access to your data, to keep costs down, and you would get two reports. You got the last report from us last year and it was a profile of cost and use for Medicare decedents.

This year when we consulted with your staff, what you wanted most was an early look at ways to go about

meeting your mandate for this BIPA report to look at hospice access. And the way I read that mandate, the mandate specifically asked you to look at urban-rural differentials, short stays, and differences in use by the diagnosis of the patient. So that's why I'm here.

Let me go on and do recent trends. Here in one slide I've tried to condense the hospice industry to a handful of numbers. Most of these numbers came from an excellent GAO report that came out in 2000 that profiled the hospice use in the Medicare program and looked specifically at the short stay issue. There's only one number on this slide that isn't from the GAO report and that's the number I came up with for nursing homes, but the rest of it is basically public use information.

The number of hospice users in the Medicare program more than doubled over this period and the use rate went from less than 9 percent of decedents to more than 20 percent or about 20 percent of decedents between '92 and '98; tremendous growth. There was a substantial diffusion of hospice out into rural areas. So that at the start of the period rural rates were a little more than half of urban rates, and by the end of the period rural rates were up to

three-quarters of urban rates.

So to the extent that there was a particular rural problem with access to hospice care, I guess the good news is it's better now than it was because the rural rates are closer to the urban rates now.

The case mix changed substantially over this period. So at the start of the period 77 percent of hospice patients were cancer patients. That's the traditional base for hospice users. And by the end of the period it was trending down toward 50/50, cancer and non-cancer. That change in case mix is going to come up again in the discussion of short stays.

Going hand in hand with that change in case mix has been the phenomenal growth of hospice in nursing homes. I have little tilde signs in front of my numbers that are 15 percent early in the period, 35 percent later in the period, because I looked at a variety of sources and there's some uncertainty as to exactly what fraction of hospice users are in nursing homes. But there's no uncertainty among any of the sources I looked at that it's the fastest growing segment of the hospice industry.

You should be aware that this raised some eyebrows

at the Office of Inspector General in the mid-1990s. They didn't like some of the contracting arrangements and they pointed out that as far as they could tell it was substantially cheaper for hospices to serve patients in nursing homes than to serve patients in their own homes. I think that's a finding that makes a lot of sense. Certainly the travel costs are lower. They found that the service levels were lower for nursing home patients. So it raised some eyebrows, but there was no action on the OIG's part. They just raised some questions.

Finally, this is the key issue for the industry I think, short stays have increased dramatically. The rounding error on my chart hides it, but roughly speaking, the number of short stays has increased by almost half between 1992 and 1998. Short stays here are arbitrarily defined as stays less than a week. It's still a trivial fraction of all the days but it's, apparently, a pretty substantial cost burden for hospices because they have to go through all of the burden of enrolling the person, then all the burden of disenrolling them, so to speak.

So that's my capsule summary of the trends in the hospice industry for the 1990s.

Let me give you the broader perspective on the entire Medicare fee-for-service program. Probably the most interesting finding, it's almost a byproduct of this report, was to say, that's great. We have hospices and they're treating an increasing share of the Medicare decedents. What's happened to site of death in the fee-for-service as a whole?

To generate this table I took a relatively small sample of beneficiaries and broke them into people who died from cancer and died from other causes, and then broke their sites of death into three pieces. If you died in a hospice, I called you a hospice site of death, regardless of your actual physical location of death. And if you died outside the hospice I went and looked at the Medicare bills and found all the people who died in inpatient settings, which I defined as hospitals and skilled nursing facilities, because there's a lot of fungibility in the site of death there, and people who died elsewhere.

The interesting finding form this chart is that while hospice has grown substantially, the site of death for Medicare beneficiaries hasn't really changed very much at all. In fact it's changed only minimally. This has

implications basically for every study you've ever seen of the cost savings from hospice, because hospice cost savings are based on the assumption that if you didn't have hospice there people would be dying in the hospital. These results seem to suggest that, no, to the contrary, that people who are attracted to the hospice appear to be the people who wouldn't have died in the hospital anyway.

The bottom line here is that despite the tremendous growth, for example, in the fraction of cancer cases from 37 percent to 51 percent in hospice, in fact the number, the fraction of beneficiaries, cancer decedents dying in the hospital only dropped by 4 percent. And on the non-cancer side, despite a 6 percent increase in the fraction of non-cancer decedents in hospice there's been essentially no change in the fraction of non-cancer decedents dying in the hospital.

So that's just an interesting caveat. If you're going to make your decisions in the context of, we all know hospice saves us money because, this is an interesting caveat to the existing studies of hospice cost savings.

DR. ROWE: Chris, could I ask a question? How could the proportion -- can you reconcile or need to

reconcile these data with the data that showed that the proportion of hospice patients who are cancer patients has gone down so dramatically? When you look at the non-cancer in hospice, deaths have only gone up from 4 percent to 10 percent.

DR. HOGAN: I'm not tracking the question.

DR. ROWE: Has there been an increase in the size of the non-cancer deaths population rather than just a shift in it?

DR. HOGAN: No, still it's only about one in five Medicare beneficiaries dies from cancer. So that the number of non-cancer deaths in hospice is actually quite large because the population is four times larger than the cancer decedents.

DR. ROWE: Can you break the inpatient and SNF down? Is that mostly hospital or --

DR. HOGAN: That's mostly hospital, but not hugely mostly hospital. There's enough patients dying in the SNF that you want to include that in the package I think. My take on it was that there was a lot of substitutability between the exact site of death for people who have an inpatient stay followed by a post-acute inpatient episode.

So I pooled them, because I thought that that was the right thing to do. But if you had a larger sample size you could certainly break that down and get those numbers.

DR. ROWE: The reason I ask, and I'll get off this, is that with the pressure to reduce the length of stay in hospitals, one of the -- there were two pieces of ripe, low-hanging fruit. One was admit people the day of their surgery rather than the day before. The other was transfer people who were terminally ill to skilled nursing facilities rather than keep them in the hospital, which was really the wrong place for them to be in the first place.

So I would have thought that while that total number of inpatient and SNF hasn't shifted much, that there would have been a substantial change in the relative proportions of those two as length of stay was driven down. So you might just look at that.

DR. HOGAN: If I had a larger sample of people I would have done exactly that. So that's basically all I have to say about trends in the hospice industry.

Let me give you one slide on short hospice stays. This turned out to be not hard to do with the Medicare current beneficiary survey. But you have to understand that

I've run a regression with 600 people in it, so all I'm going to be able to find are the largest, grossest effects that are going to pass your traditional standards of statistical significance.

I picked stays of under two weeks instead of stays of under one week. It's qualitatively the same population whichever way you slice it. It just gave me more people to look at so my numbers were a little more stable in this small sample of beneficiaries.

When I ran a regression, the regression had a bunch of right-hand side variables in it. What I found first was, based on the beneficiaries' self-reported diagnoses, the prevalence of short stays is strongly correlated with the diagnosis. It's not cancer patients. It's not lung cancer.

So if you look here, lung cancer patients were 13 percent less likely to have a short stay, and the people who do have the short stays are the people like congestive heart failure. That's either because the date of death is so unpredictable they just by accident die soon after they enter, or it may be that people are waiting until it's very clear these people are dying before they move them to the

hospice. Either way the fact is, when you run against the diagnoses, the diagnosis mix makes a big difference in the fraction of patients who have short stays.

I did a lot back of the envelope combining these two estimates, very rough estimates, with the GAO data and I came up with the following. About a third of the increase in short stays from '92 to '98 is directly attributable to change in case mix, or is attributable to change in case mix alone, because the non-cancer patients are far more likely, at least by this estimate, to have short stays.

The second thing I looked at after discussions with Kevin and Murray, they had brought up the issue of, if hospice isn't taking of these people, who is? That's why I decided to put in a flag for whether they had any home health care in the year of death. And it turns out that, yes indeed, the beneficiaries who had home health care were more likely to have a short hospice stay.

There are two possible explanations of that. One is, they have someone to take care of them so they don't have to be in a hospice till the very end. The other is there are administrative barriers to transfer of a patient from home health to hospice. I think the genesis of these

administrative barriers was to prevent the home health from going out and basically recruiting on behalf of hospice. But there is sort of an abrupt transition in the care team when you move from home health to hospice. That might be a barrier.

So it's either a substitute for hospice care or a barrier to hospice care; I'm not sure which. But the fact of the matter is, it's strongly correlated with having a short stay.

Then there was a cluster of demographics that as an economist I could make no sense -- I could tell you no sensible tale for these, and every time I try and discuss them I get the sines and the coefficients wrong, so I'm simply going to state them and leave them for your discussion.

Living in the community with your spouse means you are less likely to have a short stay. Being female means you're less likely to have a short stay. And being poor means you're less likely to have a short stay. Those three are all highly commingled. Most of the beneficiaries with incomes under $10,000 are women living alone who have been widowed. Yet I did a relatively careful analysis on Kevin's

suggestion to look at all possible combinations of these and these results are true: independent of your living status or your gender, poor people are less likely to have a short stay. Independent of your income or your living status, women are less likely to have a short stay.

So I probably have mixed a sine here one way or the other, but I have a cluster of three important demographic factors and I couldn't make any sense of this, so I'll just leave those for your discussion.

Probably the most interesting thing on this table is what is not on this table, and that is an urban-rural difference. That once you account for diagnoses and demographic factors there was no urban-rural difference in short hospice stays. So that's probably almost a check-off for this report, to say that was not a particular rural issue.

Let me go ahead and look geographically now at urban-rural differences in hospice use. The first thing I did was to take some data that Jennifer Grover and Laura Dummit at the GAO very nicely provided to me, a nice tabulation of hospice users from the 100 percent hospice files. I looked at it by state, and what you find is there

is no such thing as uniform urban-rural differential in hospice use. On the eastern seaboard or the northeast cost, there's no urban-rural differential to speak of. In fact in many states the rural use rate is higher than the urban use rate.

What I did was I sorted all 50 states, took the differential, and gave you the states with the largest urban-rural differential at the top of this table and the states with the smallest urban-rural differential at the bottom of this table. So you can see in Connecticut, the use rates in Connecticut are higher -- Connecticut, New York, and Maine -- are higher in rural areas than they are in urban areas. It's only when you go out to the old frontier and the upper Midwest, if you go out to the mountain states, North Dakota and some others in that general cluster, that you find that the rural rates are substantially lower than the urban rates.

But I do need to point out that if you just look at the numbers on the face of them and read down the rural column, it's not the rural rates that change. In fact the urban-rural differential is due to very high urban rates in mountain states. The rural rate in New Mexico is higher

than any of the urban rates on the east coast. So the extent to which we call this a rural access problem is problematical on the basis of that.

This was beyond my level to tell you a sensible story. I looked at that and I said, this certainly varies a lot by geography and that I'm simply going to ignore this fact for the rest of the discussion and pool all urban rates and pool all rural rates and give you urban-rural differences that pool across these state-level differences.

How do rural hospice use rates compare to urban rates by the urbanicity of the rural county? The right way to understand this chart is to realize that if I had put a line on it that said urban, the line for urban would have said 100 percent, 100 percent, 100 percent. So this is the use rate relative to the urban rate for all the rural areas as defined by their urban influence code. I broke it into cancer and non-cancer decedents, and this is based on the diagnoses on the hospice claims.

What you find is that the lower rate of use in rural areas, it's substantially lower for non-cancer diagnoses than for cancer diagnoses. So the cancer use rate is much closer to the urban rate in rural areas, and that it

varies pretty much strictly by the urbanicity of the county. This shouldn't be any surprise. So that the use rates for hospice are lowest in your totally rural counties, meaning counties that don't even have a town of 2,500, and it's highest in the counties that are adjacent to urban areas or that have a city of 10,000 or more.

So I thought that this chart, in a single chart you pretty much know the story here. The more remotely rural you are, the less likely you are to have access to hospice care, and non-cancer care is primarily an urban phenomenon. Cancer care for hospice has diffused to a substantial degree to rural areas.

The final piece of this was to say -- and this was once again at your staff's suggesting -- are there any places where we have evidence of no hospice availability? This is the crudest possible way you could measure hospice availability you say, there's no hospice there. So I looked at a bunch of different sources of data to try and find any availability of hospice.

What I found is, yes, indeed, the rural counties where there's no evidence of hospice cluster in a few states, Wyoming, Montana, Nevada, South Dakota, Nebraska.

North Dakota would have been there too, but the hospices in North Dakota claim to serve almost all the counties in North Dakota so I took them at their word. Anyway, these states -- and it was a clear geographic clustering, and if you look at the counties, of course, half of them are counties that are remote rural counties.

Let me give you the caveats and conclusions. This analysis was a -- quick and dirty is a little pejorative, but I used small sample files. I used what was available and I got the product on the table in front of you, using the simplest possible criterion for access to hospice which is, do you have any hospice care. That's a pretty rough cut at what is basically a very complex underlying decision.

In terms of conclusions, I'll give you two slides to summarize the contents of the presentation. Yes, the use of hospice care increased substantially from 1992 to '98; users more than doubled. The case mix shifted substantially towards non-cancer cases and towards care in nursing homes. The urban-rural differential narrowed; that hospice appeared to diffuse in rural areas. But overall, this has had a minimal impact on where Medicare patients die. They still die in the hospital at about the same rate as they did

before the growth of hospice.

There's been an increased use of very short stays in hospice. There was no particular urban-rural differential, but at least some of that growth can be pretty directly attributed to the change in case mix. It's the non-cancer cases that predominantly had the short stays. Maybe the rapid growth in home health through 1997 may have contributed to this, because I think that having home health was able to keep you out of the hospice longer. But of course, that whole landscape changed in '97 so these numbers are probably unhelpful for a modern discussion. And maybe the secular trend toward shorter stays may have had influence as well.

Even now the use rate is lower in rural areas than in urban areas, but as you know that's not geographically uniform. Somewhat lower for cancer cases, a lot lower for non-cancer cases, and clearly linked to the urbanicity of the area; the more urban you are, the likelier you are to have hospice available. When I've looked for counties that had no hospice at all, they were clearly geographically clustered in just a few states.

DR. ROWE: Two points, Chris. It was very

interesting. I think looking at the data that you showed that wasn't really that coherent as you looked at it about the women, and whether you're living alone, et cetera, or whether you're poor, one of the findings early on in hospice was that it was very under-utilized by minority populations, particularly African-American population compared to others. I think 3 percent utilization rates or something like that. I don't know if that's held up over time.

This was in areas in which there was access, and it was felt that perhaps a different social structure, with more people at home, more multi-generation families living in the same area, et cetera, there was more support, informal social support. Therefore, there was less need for hospice. I don't know whether those data have held up. My information is a little old on this, as it is in much of clinical medicine unfortunately.

But nonetheless, that might explain what your observation about these things just don't seem to tie together. If your sample is large enough you might look at African-American and/or Hispanic. You might have to put those two together but you might be able to do that. That might answer this question.

I don't think that's a bad thing. If we find that, this shouldn't be an initiative to improve the use. People should use whatever resources that are available. Those are the best resources. And if not, then we should supplement them with formal resources for those people who don't have the informal resources. So I don't think it would be as bad thing if utilization is lower but it might explain the data.

The second point I would make with respect to this is, I think this is very important and useful. We were asked by Congress to do a very specific rural hospice benefit, another one of these very targeted requests that somebody got Congress to ask us to do, which is fine.

But this should not be a proxy for MedPAC's interest in care of the dying, or care at the end of life. There is more to care at the end of life than hospice, or whether hospice is available in all areas. There are lots of aspects of care at the end of life, including the education of physicians and nurses and others, and utilization of other resources in the community, and home care, et cetera. So I just want to make sure from a policy point of view that from time to time we get to this issue

and we shouldn't just assume we've taken of it because we've done this project on hospice.

DR. REISCHAUER: This really isn't on the focus of what Congress asked us to do, but I was wondering, Chris, if you had some information on costs. We went into the hospice movement for two very different reasons. One was that this was a more desirable or medically appropriate setting for the end of life. And secondly, that it might save Medicare a lot of money.

I was wondering if there are any data that show trends over this period, breaking the population of decedents into those with any hospice in the last year, those with no hospice but inpatient, and those with neither inpatient nor hospice care and what's been happening to those? Because I got a feeling from what you said that maybe these differences are narrowing.

DR. HOGAN: I ran a cross-section of those numbers last year so we know the picture that people dying in the hospital cost about twice as much as people who don't die in the hospital, so that's well known. Whether there were trends in those numbers, I found it -- I don't think I had enough data to say that very well, although I could go back

and look.

DR. REISCHAUER: But whether they die in the hospital doesn't tell you whether they had hospice care at some point.

DR. HOGAN: No, having divided the population into any hospice, and of those with no hospice, those who died inpatient and those who died elsewhere, you'll find the people who died in the hospital cost substantially -- as expected, they would cost about twice as much; substantially more.

The only trend number I have is that in the aggregate in the Medicare program the cost in the last year of life are essentially no different from what Lubitz measured in 1979.

DR. ROWE: Twenty-two percent?

DR. HOGAN: Twenty-six and-a-half, 27. Certainly there's been no -- if you merely bucket people by the fact of death there's been no change in the fraction of Medicare spending on those people in the last 20 or 30 years. That doesn't answer your specific question about --

DR. REISCHAUER: No, it doesn't, but it would then suggest the difference between those who die in hospice or

those who die in a hospital has shrunk, I think.

DR. ROWE: I think what you have to do, Bob, is you have to break the deaths in the hospital into the kind of schedule of deaths from chronic or semi-acute diseases, and the deaths of people who have acute myocardial infarction or stroke and die within the first couple days of arrival in a hospital. That would give you more information about the comparison.

DR. HOGAN: There was a suggestion to look at the time series within geographic areas and see if the areas where hospice increased its penetration most rapidly resulted in a reduction. That analysis is just waiting to be done. So there are ways to get at it. They're all sort of indirect. I give you an aggregate table. If you had 100 percent data you could do a disaggregate table.

But the issue of whether or not there's been a secular shift in the change due to the growth of hospice that's an important question, but I don't think I could do it by putting people into, by bucketing people by hospice and site of death. I think you'd have to use more indirect methods.

DR. NELSON: Chris, I'm starting from the position

that hospice is a valuable service and that it provides an additional choice and an asset for Medicare patients that are eligible and want it. To what degree -- I didn't see that your data measured it directly but can you give me an idea about capacity and the degree to which the use of hospice services is being restricted because of waiting lines, or because of a lack of hospice availability, other than just as explained by geography?

DR. HOGAN: No, I couldn't even begin to -- I don't know how I'd identify a beneficiary who tried to get hospice but couldn't except via survey. No, there's nothing that --

DR. NELSON: I guess as a practitioner I had patients tell me that they were trying to get into hospice, that they had a waiting list, that when they finally made it they were really happy. I think that we're talking about the economic implications, whether or not Medicare is providing adequate incentives to payment policies for hospices to form and stay in business. It seems to me that we can't approach that question unless we have some sense about whether there's an adequate capacity, or whether we need to sweeten the pot, or whether the pot is perfectly

sweet and everybody that wants hospice can get in. I guess at some point our staff needs to think about how we might get that kind of information.

MS. RAPHAEL: I was interested in several things that you highlighted in the text that you didn't refer to today. One is that the percent of hospice users who use it for four weeks or less, as I recall also went up by about 12 percent, and I thought that was interesting. I was wondering if you could comment on that.

Secondly, you also mention the fact that if you are a member of Medicare+Choice or you have a Medigap policy you're more likely to use hospice. That's in accord with my own experience, that we have a very high percentage of Medicare+Choice and Medigap policyholders in our hospice program. It really is striking compared to home health care utilization, for example.

DR. HOGAN: Comments on the two of those. The four week or less, I had nothing of interest to say there. There's been such a secular decline in lengths of stay that I thought that that would just -- putting any arbitrary boundary on a reasonable length of stay seemed like you're going to have -- because stays have been falling generally,

you're going to have more people falling into that boundary. I didn't have any -- I don't think that's where the industry's interest was focused and I didn't have anything in particular to say about that.

With regard to Medicare+Choice and Medigap, I found those -- as an economist those are puzzling, because these are the people who have complete coverage, or more or less complete coverage. For Medicare+Choice, I have my own suspicion that there's a lot of a case mix effect there. That the beneficiaries who are dying in Medicare+Choice are predominantly cancer, or more likely to be cancer deaths than others, because you don't get -- people who already have substantially crippling congestive heart failure are less likely to enroll in a Medicare+Choice plan and they'll stay in the fee-for-service program.

The short answer is, I thought that a piece of the Medicare+Choice answer was case mix. That the predominant Medicare+Choice decedent. But I have absolutely no evidence to tell you that because I have nothing to look at.

For the Medigap result, it was anybody's guess as to why people with Medigap would be more likely -- I assume it's a sociodemographic thing that I haven't measured. They

are wealthier, or they are better off, or they're better situated, or something. Or they're more interested in complete coverage and so that's why they're willing to go into a more comprehensive care at the end of life. Couldn't give you a reasonable response to that.

MR. HACKBARTH: Anyone else?

MS. BURKE: One of the things you didn't talk about in the text and don't refer to in the context of this first analysis is the issue of the structure of the benefit itself and the decision ultimately that has to be made by the patient with respect to the choice of palliative care as compared to curative care, and whether the way we have structured it and the fact that people have to make a choice has had a major influence on a decision to use hospice. That you essentially acknowledge where you are in your treatment and essentially give up traditional treatment. And whether that timeframe, the prediction of six months left to live, whether those things have had an unreasonable influence, or an inappropriate one on the decision to seek hospice.

The shortening of the period of time, how late in the process people go in order to choose to go into hospice,

how much of that is given by the way we've structured the benefit? I didn't know whether ultimately -- I mean, you touch on it in the outline at the outset -- whether ultimately you expect to look at that issue at all.

DR. HOGAN: No, you have my ultimate product right here. Now it's your report to do with as you see fit. Certainly the six-month prognosis, as has been pointed out by many people, is the reason that you don't get many --

MS. BURKE: You see that in one of your charts where that's indicated as a significant indicator.

DR. HOGAN: You'll see that in the next presentation discussed pretty explicitly, and I think everybody in the hospice industry points to that and says, this is a problem. So yes, there is something to be said there, but I was not the person to say that.

DR. STOWERS: Chris, I just had a quick question. On this counties with no evidence of hospice, how did you break that down, and how many total states have at least some counties without -- because I know of a couple that aren't on here that --

DR. HOGAN: There's a state-level chart in the report showing the percent of rural decedents in counties

with no evidence of hospice. So you just have a state-level number, and most of those round down to zero. So if there were a small county in a large state it would show up as zero on the chart.

MR. HACKBARTH: Thank you, Chris.

DR. KAPLAN: Jay Mahoney has been involved with hospice since 1982. He was the CEO of the National Hospice Organization for 15 years, that now is known as the National Hospice and Palliative Care Organization. And for the last four years he's been consulting with hospice organizations.

MR. MAHONEY: Good morning. While Sally is working at putting the slides up I think we'll just offer a few quick introductory remarks regarding the interview process with our key informants.

Our interview instrument asked the key informants to tell us what they felt were the most important barriers to access to the Medicare hospice benefit. We did not try to assist their response by providing a list of possible responses to rank order, nor did we ask them if any specific issue was a barrier to access. Obviously if we had asked for a rank ordering or a yes/no response to a prescribed list of barriers we may have received a different response.

For purposes of this interim draft report I have collapsed similar responses into categories of response. You should also know that not every informant responded to every question, while others had something to say about everything.

As this slide suggests, the overwhelming response to our question about access was that indeed eligible beneficiaries do experience difficulty in accessing the Medicare hospice benefit. Our key informants responses suggest that issues of access can be separated into those barriers that prevent patients ever being referred to a hospice from those barriers that simply result in late referrals. There are similarities in the barriers, but they are not identical, and similar barriers may influence the two categories of access to different degrees.

This slide generally represents what the key informants reported were the most significant barriers to ever being referred to a hospice program. The requirement of a six-month prognosis appears to be the most significant barrier to ever being referred. Doctors do not like to make such prognostic determinations, and the literature would suggest that when they do make such determinations they are

more often than not wrong.

Discussions about prognosis are difficult. Doctors are not particularly well-trained for this type of discussion and often times the patient and family do not want to engage in this discussion. Some have suggested that accepting a referral to a hospice program is an admission of hopelessness and impending death.

Another issue of note that was reported to us was the inability for a patient in a skilled nursing bed to access hospice care. The patient often makes this choice for financial considerations, but in doing so the patient may not access hospice care. Some suggested that by making the choice the patient is prevented from receiving optimal end of life care.

Many of our key informants suggested that some hospices contribute to barriers to access, although several informants also noted that such actions by hospices are sometimes a matter of survival rather than choice. Concern about admitting a patient who will ultimately prove too expensive for the hospice to care for is certainly an issue for some hospices, and we will discuss this issue in later slides. Some hospices operate under a very strict

interpretation of what constitutes appropriate hospice care, resulting in their limiting their own admissions.

Regulatory concerns were also frequently mentioned. Key informants reported that hospices are concerned about being denied payment or being required to provide burdensome levels of documentation to substantiate an admission. As many hospices lack the resources to appeal denials or provide additional documentation, hospices simply adopt more rigid admission criteria.

Patients with non-cancer diagnoses were identified as the group that faces the most difficulty being referred to a hospice program, although the literature suggests that this population is a growing proportion of hospice patients. Certain ethnic and racial minority groups continue to face barriers to hospice care for a variety of reasons, none of which appear to be a result of specific requirements of the benefit.

However, in answer to one of the questions from the previous presentation, the data that we have would suggest that the number of minority groups being served by hospices has grown substantially but probably still is not to where it should be.

Patients in nursing homes face barriers. These barriers are the result of the skilled facility issue we previously discussed, as well as a reluctance on the part of some nursing homes, as well as hospices, to create relationships with each other. The older-old appear to face barriers, which are probably the result of a combination of caregiver issues as well as residency in nursing homes.

This slide talks about the reasons for short lengths of stay. I think it's important to note that the impact of a late referral diminishes the hospice's ability to provide quality care to the patient family. The literature suggests that physicians report an optimum time for hospice involvement to be three months. Additionally, a decrease in length of stay, coupled with an increased intensity of services, increases the per diem cost to the hospice for each patient.

Although as I mentioned there appear to be similarities between the barriers identified to ever being referred to a hospice and those identified as barriers to timely referral, there are important differences. The most significant to timely referrals include the availability of less toxic therapies and the Medicare hospice benefit

requirement to forgo curative care.

In recent years, medicine has made available therapeutic agents that allow patients to attempt cure of their disease without the debilitating side effects. While the probability of cure may be no greater than what it was, the choice to try such therapies is not so difficult to make as it may have been at one time. These therapies may also be quite appropriate as palliative interventions. However, in either case, the cost of these therapies which are otherwise generally covered by Medicare can be prohibitively expensive for most hospices to cover under their per diem payment program.

In previous slides you may have noticed that our key informants identified the lack of physician and patient knowledge about hospice care as being important barriers to access. When asked what would improve the consumers' understanding of the Medicare hospice benefit, based on the idea that an informed consumer would be in a better position to ask their physician about hospice care, many of our informants suggested that the greater effort should be focused on educating the physician.

The question was posed, what uniquely rural issues

affect access to hospice care. Our key informants suggested to us that when a hospice in a rural area stopped serving an area, it is unlikely that another hospice will step in to serve those patients, so hospice care simply becomes unavailable. In urban areas, other hospices almost always step in to fill and service gaps.

Our key informants reported that the most significant problem facing hospice serving rural areas is the challenge imposed by the great distances involved in caring for some patients. The challenge of distance directly contributes to the cost of care, as well as indirectly, by requiring the hospice to recruit and retain additional staff.

Another issue was a general lack of services was identified in several different ways as contributing to the challenges facing hospices in rural areas. Such things as lack of wireless availability for pagers as well as cellular phones complicates on-call coverage. A lack of public transportation, other professional services, auditing firms, educational services, even office supply stores, all add to the cost of care in rural areas.

Recruiting and retaining qualified staff is a

challenge in many part of the country. However, our key informants reported that this problem is even greater in rural areas where, if qualified staff can be found, they are often willing to commute rather long distances to obtain the higher salaries available in more urban settings rather than accept the lower salaries offered by rural hospices.

The ability to take on the risk of serving potentially costly patients is limited by a small census. Now census size is obviously not an issue of geography, but in rural areas hospice providers generally do not have a choice about their small size. Small hospices in urban areas can grow larger or merge with other programs. These options are seldom available to small, rural programs.

Our key informants had many ideas for improving the Medicare hospice benefit. Some of the options most often mentioned included modifying the six-month prognosis requirement. Our key informants had many suggestions how this might be accomplished, but the idea of determining eligibility based on some type of functional assessment of the patient that may indeed by built around a limited prognosis but that does not specify an exact period of time that a patient has to live was suggested by several.

Other key informants suggested that the benefit should be expanded to include ongoing consultative hospice services, while others suggested the creation of a residential level of hospice care.

Modifying certain payment policies was also suggested, including the adoption of an outlier policy and/or some mechanism to limit the risk to hospices of caring for people receiving costly therapies.

In addition to these suggestions, our key informants identified several other issues including re-basing the hospice rates as areas for additional further study.

That's my presentation. I'll be glad to take any questions that you have.

MR. HACKBARTH: Questions?

I have one, John, about the short lengths of stay. You have the graph, the most important reason for short lengths of stay. Here there's no reference to case mix or any of the factors that Chris identified as correlating with the decline in length of stay. Can you shed any light on why the people you talked to didn't identify those factors?

MR. MAHONEY: I don't know that they were thinking

about it in terms of case mix. I think generally speaking -- and this answer is a combination of what we heard from our key informants as well as what's in some of the literature, non-cancer patients have more difficulty ever being referred to the hospice program. But in many cases, those patients with non-cancer diagnoses who are referred to the hospice program actually have longer lengths of stay than you'd find on average.

Cancer patients, on the other hand, generally are referred to hospice programs and don't seem to have a great deal of difficulty in being referred. But there seems to be greater problems in terms of their being referred on a timely basis.

DR. NELSON: John, I'll ask you this question so Sally doesn't have to fuss with it. I assume from the fact that you don't have any bars on your graphs that suggest that capacity is a problem. That is, that patients who are eligible and referred don't have to wait in a queue to obtain hospice services. I'm making an assumption since you didn't include it among the barriers, that indeed, capacity is just fine and that's not a factor. If that's the case, then I'll shut up on this point.

MR. MAHONEY: I think that the question is a good one and you actually shouldn't shut up about this point actually. I think that we're not seeing a lot of that issue surface just yet across the country. I think that where we do have capacity issues, are associated with hospice programs that have no inpatient programs. So where you might find waiting lists is where people want to access an inpatient hospice program and they don't have access to that because the beds are filled and they simply have to wait.

Another area that we're beginning to hear more about, but it's on an anecdotal basis. And again it actually goes to rural issues where hospice programs are simply having so much difficult recruiting and retaining qualified nurses that in those cases they're simply having to stop taking patients for a period of time because they can't find anybody else to do the work. But we don't have any real data on that that I could say is national data.

MR. HACKBARTH: Any others?

Thank you, John.

DR. KAPLAN: This report is due in June 2002. We believe that we have a story to tell about beneficiaries' access to hospice. By synthesizing the information from

these two studies and other sources that are available, other studies that have been done, we do not anticipate any additional work on access at this time, unless of course the Commission directs us otherwise. We will begin looking at suggested policy options from a number of sources, including these studies. We'll evaluate the advantages and disadvantages of the options and include them in a discussion in the report. You'll see the synthesis and the discussion of policy options in March.

One problem we face in discussing payment policy options is that the hospice cost report data will not be available for use in the June report, at least as far as CMS has been able to let us know at this time. As a result, the solution part of the report will be conceptual.

We'd like your comments, questions, directions.

MR. HACKBARTH: Any comments or requests?

DR. NEWHOUSE: I'll hold on the discussion of payment policy options until we get there. In terms of the urban-rural differences that have been discussed, one of my concerns is that informants -- maybe I should have directed this to John -- I wonder whether they really know urban and rural costs. CMS doesn't know, for example, travel costs

separately. You have to see some data that compared them. Even then you'd have to wonder, given the data Chris showed on the heterogeneity of the rural, what really you had. So I'm a little skeptical that somebody can just report about urban and rural and that we should lay much weight on that.

Second, I would say that lower nominal wages in rural areas are presumably to some degree offset by lower cost of living, but that's hard to quantify. Those are really just caveats on trying to interpret urban-rural numbers.

MR. HACKBARTH: Any reaction to that, Sally or Kevin?

DR. KAPLAN: I agree with you. I think that not having the cost report data, and as we found with the home health study in the rural report, it's very difficult to find travel costs on the cost report. What CMS basically concluded about home health agencies, which have a similar problem in rural areas of travel costs, is that the rural travel costs were basically offset by urban costs such as a monitor or a person to ensure the safety of the home health professional, would offset the rural travel costs.

DR. STOWERS: Maybe someone could help me. We're

talking about the cost, but is there a payment difference? Is there a geographic adjustment, and how much is that? What would be the differential between an urban and --

DR. KAPLAN: There is a wage index, and it's not clear to me -- I can't remember at the moment how much of the payment is subject to the wage index. But there is a wage index.

DR. STOWERS: I was just curious what the dollar difference in a visit would be, or an episode.

DR. KAPLAN: They get paid by day. In other words, each day that a person is enrolled in hospice, the hospice is paid a daily rate based on the type of care they receive during that day. For instance, if they received routine home care then they're paid for routine home care for that day. Then that rate has a labor-related portion that is subject to the wage index. Right at the moment I cannot pull the table up in my mind that has what the labor-related portion on the routine home care would be.

DR. STOWERS: My question is, the cost very well may be different, and the payment may be different, but I wonder how the two are matching, or whether we're actually reflecting the real cost compared to the payment. I think

it's something we need to look at.

DR. KAPLAN: It is something we need to look at. But I think the point is that hospices have not submitted cost reports until very recently, and the cost reports were theoretically going to be available in 2001. But as you know, all cost reports have been delayed for the last cycle for 2000. So it's going to be very difficult for us, without cost reports available, to give you any idea about differences between costs and payments, differences between rural and urban in cost. We can give you an idea of differences in payment.

There's also the issue of the fact that these rates were established based on a demonstration in the early '80s, and although they've been updated those rates were really structured very differently from the way the hospice benefit is now. But there's no way to really look at anything to see whether the rates are appropriate or not without the cost reports.

DR. NEWHOUSE: That's the larger issue, Ray. This thing for urban-rural is just the entire base for the rate, both urban and rural.

DR. STOWERS: Exactly. I agree. I know, for

example, in the county that I practiced in, when we finally did get hospice that we were actually paying more hourly for the nurse's care than what they were paying in the larger cities just to get the nurses out into that area. So I think sometimes the cost of living or wage index is kind of skewed that way when you really have to go to these remote areas.

DR. BRAUN: Just a point of information. If a Medicare beneficiary in a nursing home who is on Medicaid in a nursing home, if they go into hospice what happens with the benefits?

DR. KAPLAN: If a person is eligible for Medicaid, Medicaid pays the hospice and the hospice pays the nursing home, I think it's 95 percent of the daily rate. Then also the hospice receives the hospice rate for the hospice care.

DR. BRAUN: It still seems to be some duplication.

DR. KAPLAN: When Chris referred to the OIG, that was part of the OIG's point is that there could be some overlap, and it appeared that they found that some of the hospices were really using the nursing home personnel to provide care and were not providing all that much additional care.

MS. RAPHAEL: Sally, I'm assuming that because of the lack of cost report you couldn't tell us, as we've seen in other sectors, what the financial performance looks like for hospices?

DR. KAPLAN: You're right, we cannot.

DR. NEWHOUSE: The freestandings would have to break even to stay around anyway, so to some degree the costs are just going to reflect what we pay. So then there's a judgment about, what are we buying for what we're paying, that's going to be hard to make.

MS. RAPHAEL: I think a lot of freestanding that I know about do considerable fund-raising to try to make up the deficits. I don't know how prevalent that is.

DR. KAPLAN: I think it's pretty prevalent. Of course, they're required to get in-kind contributions through volunteers. So not only are they fund-raising to raise funds, but they can use the volunteers. But then there is also a restriction that a certain proportion of their services, a very large proportion of the services have to be provided by their own employees, which appears to be to keep contract employees from being used extensively, except in peak periods or in emergencies.

Any other questions or directions?

So the timing of this report, with Congress asking for it in June 2002, if the cost reports had come in when they were expected to come in and basically had been edited and CMS was confident about them, we could have given them a whole lot more information. But as a result of the cost report problem, much of our discussion of the solutions to the problems in access are going to be conceptual.

But that doesn't mean that we can't make recommendations such as, when the cost reports are available, we direct you to look at them and consider re-basing, or something like that. But we're not going to be able to come up with a very -- as firm a statement as we could with the data.

DR. REISCHAUER: Your description is that Congress thought the cost reports would be available when it set the timetable for our report and we can't give them really what they want because the cost data isn't available. Does it make sense to do this that way, as opposed to go to Congress and ask -- is this in legislation so we couldn't do a three-page letter saying, we're fulfilling to the extent possible the requirement, realizing that we really can't fulfill it

until the cost reports are available, and we'll report back with a more substantial --

DR. ROSS: I think we give what we can by the statutory deadline. It doesn't end the Commission's interest in this or future work. The analog here might be the GME teaching hospital study where we provided a very short, conceptual report to meet the statutory deadline and did a lot of follow-up work.

DR. REISCHAUER: Because I sense there's a lot of interest on the Commission on doing this right.

MR. MULLER: Is there considerable or any kind of cross-ownership between home care and hospice.

DR. KAPLAN: There is some, yes. But I don't want to say it's considerable. It's actually less than I thought it would be. One of the confusing factors is that you have hospital-based hospices. Hospitals can have a hospice, and they can have a home health agency, so they're related. But you wouldn't really identify that because it would be a hospital-based hospice.

MR. MULLER: But independent of an institution like that --

DR. KAPLAN: There are a number of freestanding,

and there are more freestanding hospices now than at the beginning of the '90s.

DR. NEWHOUSE: But I thought 90 percent of the care was delivered in the home.

DR. KAPLAN: That's correct.

MR. MULLER: If there's a payment advantage to going one direction or the other, you reorganize yourself.

DR. REISCHAUER: Are there for-profit entities?

DR. KAPLAN: Yes, there are for-profit hospices, yes.

DR. REISCHAUER: When we're talking about the adequacy of the payment, it might be interesting just to look at the trends in the growth of numbers and capacity in the for-profit sector. It should tell you something about the adequacy of payments.

DR. KAPLAN: We can do that.

DR. REISCHAUER: And also about their locations, too.

DR. KAPLAN: Exit and entry, if we consider that exit and entry is an indicator of payment adequacy, if you'll excuse my using adequacy without defining it, then we would say that the hospice payments must be decent or

appropriate because we've seen a lot of entry.

DR. NEWHOUSE: But there's a problem, because they may be adequate to make a profit provided you get the right case mix, and you may decide there's certain classes of patients that you're not going to take because the rate doesn't suffice.

DR. KAPLAN: Right.

DR. REISCHAUER: But at the same time, Chris' numbers, if they hold up past 1998 show a substantial growth overall.

DR. NEWHOUSE: There's no question in my mind that the rate is quite adequate for many patients.

DR. ROWE: I think this conversation reflects the possibility that individual hospices, be they for-profit or not-for-profit, may have more than one payer. If you just looked at whether nursing homes were open and said well, they're still open, so the Medicaid payment rate must be adequate. But then you go to the nursing home and you see they have a certain proportion of private pay clients and they really require those in order to get by. If it was just the Medicaid patients, many of the nursing homes might not be able to get by.

We shouldn't assume that whether a hospice is making it or not, or there's entry or there isn't, is a direct reflection of the Medicare payment rates until we look at what proportion of the patients in these hospices are from private pay or commercial payers or whatever.

So if you're going to look at the for-profits, you might look at the proportion that are Medicare beneficiaries in addition to whether there's entry or exit.

DR. KAPLAN: For which we need the cost reports.

DR. NEWHOUSE: But we know that about roughly three-quarters of the decedents of all types are Medicare.

DR. ROWE: One-quarter private pay would make a huge difference.

DR. NEWHOUSE: In our interviews with the hospice industry, the industry on a whole seemed to like Medicare, to deal with Medicare because of the flexibility within the all-inclusive rate that Medicare afforded.

DR. STOWERS: I was just going to say that while we're looking back to the volunteer versus profit or hospital-based, I know in our region what hospice care there is, and there are several gaps in several counties, that it's all volunteer organization driven and there's fund-

raisers and all sorts of things. They by, are by no means, being supported by their Medicare income.

So I think whether it's urban versus -- you know, I think some of these communities have got together to bring in other resources to make this work. But they're sure not making it on Medicare income alone, I know that for sure.

MS. BURKE: Sally, I wonder as you began to think about the report and reflecting on that charge from Congress, in addition to the payment rate issues that we've spent a fair amount of time talking about, there are a series of issues about internal limits, use of inpatient days, and a variety of other things that were part of the initial benefit. And I wondered to what extent you anticipate looking at those issues, and to the extent that they limit people's use or have an influence on people's use of the benefit, as well?

DR. KAPLAN: I think we are going to look at some of the issues. In fact, I know we're going to look at some of the issues that have been named by the key informants as potential access problems or barriers to access, and try to come up with a discrete number of solutions that might solve those. And then discuss them in terms of the pros and cons

of doing that. Particularly I know we're going to look at the six month prognosis issue.

Some of the other issues really get into more -- we had planned, when we looked at this, because of the way the mandate really is stated, is to look at it within the context of the current benefit. So we really had not planned to get into the larger aspect of "end of life" care. We really were going to look strictly at hospice.

But as Dr. Rowe said, it doesn't restrict the Commission from looking at end of life. It's just that in this report we're going to do it in the context of the current benefit.

MS. BURKE: And it's in that context that I asked the question. There were, at the time we created this benefit, a series of decisions made because of concerns, both in the construction of the demonstration as well as in the final benefit, concerns around use -- because we didn't know enough at that point in time. Concerns about the mixture of services. The limit on the inpatient days was designed for that purpose, so that you essentially didn't try and go around it.

But there are now issues around the nature of

treatment that have changed substantially since the benefit was originally enacted. And things that might have been viewed as curative at that time are really now palliative and are not really curative. Issues around certain chemotherapeutic agents.

And so as we look at the issues of payment, I don't want us to lose sight of the fact that in the current construction of the benefit there are a series of decisions that were made inherent to the benefit that may warrant relooking at now because of what we know in our experience with the benefit.

DR. KAPLAN: I think that definitely we'll be getting into the issue of the --

MS. BURKE: Pass-through issues?

DR. KAPLAN: Really, the fact that you have chemotherapies that are less debilitating now that are available. And some of those have been approved by the FDA as being appropriate for palliative. Not all of them have been approved as being appropriate for palliative. So I think we can discuss that issue, as well.

MS. BURKE: Thanks.

MS. RAPHAEL: I agree with Sheila that I think one

of the major issues here is [inaudible] and trying to put a treatment into one of those boxes, as well as just dealing with more chronic illnesses where you progressively deteriorate and it's hard to demarcate when they're terminal.

But also another factor that I think is important to consider, are some of the regulatory issues that have really driven the costs up. And I think they were well-intentioned but have not necessarily been constructive. For example, this issue of not contracting out. I think that it had a very good purpose. But for example, you can contract out for infusion therapies which you would want to do from a quality standpoint because you want a few specialists who really do high volumes. But you have to have one or two people do very few cases and it's just not cost effective.

There's also a requirement that every time you make a change in treatment the whole interdisciplinary group has to approve that. And I think it really tried to promote multidisciplinary care. But it means if you change a medication you have to reconvene your group and really review and approve that.

There are just a number of things like that that I

think had a very good public purpose initially but, in effect, are really raising costs.

MR. HACKBARTH: Anyone else? Kevin?

DR. HAYES: We would like to talk to Carol further if she's got other ideas along that line. That sounded like a very fruitful way to proceed, to pursue some of those things.

MR. HACKBARTH: Thank you.

What we're going to do now is return to the subject of quality improvement for health plans and providers. As you recall, yesterday we left the subject without voting on recommendations. We asked Mary and Karen to try to capture the essence of the discussion we had in some alternative recommendations which they're going to present now. We can have some brief discussion and then proceed to a vote.

MS. MILGATE: As you remember, yesterday we were discussing four draft recommendations. Just to let you know what you have in front of you today, we came back with two options for the recommendation where there seemed to be some differences of opinion. And we hope that one of the two options represents at least what your opinion may have been

on it.

Then the other three recommendations are not significantly changed. Glenn, do you want me to go through the first options first? Or do you want to go through the options that don't have as many changes, first?

MR. HACKBARTH: Why don't we focus our efforts on those first couple where there is an issue. You may also want to mention how you responded to Sheila's point about the --

MS. MILGATE: Putting one first, versus the other.

Yes, what you'll find, first of all, is that we changed the order of recommendation one and two, so that the Congressional question of how to apply quality improvement standards and the issue of the comparable standards is actually addressed in the first recommendation, whereas yesterday we had the one on duplication of efforts first.

So you'll see that there's option one and option two for recommendation one. And then we go through the other recommendations.

I wanted to just very quickly summarize a little bit of what we heard yesterday to identify a few of the issues, and then just go right into the recommendations.

Yesterday I think we heard basically three competing beneficiary needs voiced in a variety of different ways. It seems to me a good way to look at the first two options is to think about how those beneficiary needs are addressed within those options.

First is a beneficiary need for high quality care. So just a general support for that as a concept.

Second, a beneficiary need which Bea brought up on equal protection across plans and providers in geographic areas. And of course, that's kind of the heart of the issue that folks discussed yesterday, is whether it's really appropriate to have different levels of standards on different plans and providers.

And then thirdly, a beneficiary need for choice. So that gets at the issue of you don't want to have the standard so high that, in fact, it restricts entry into the Medicare program or makes it extremely expensive for those certain types of plans or providers in the program to stay in the program.

So turning to the slides, the first option recognizes the discussion that, in fact, there should be some differences in how quality improvement standards are

applied. That was a recommendation we had yesterday, but it has the added piece of suggesting if you do that, there should be some kind of reward or compensation for that. So this option -- and let me just read it -- is that the Secretary should take into account the capabilities of providers and plans when developing and applying quality improvement standards. If this results in an uneven level of quality requirements, Medicare should compensate plans and providers who incur additional costs.

So theoretically, that addresses the flexibility issue and says if, in fact, that means there's higher requirements you should compensate those who incur additional costs. Practically speaking, there are clearly some problems with implementing this. If you're talking about payment differentials, you'll have to figure out how much cost you're actually incurring. You would end up probably having to do that on an individual basis because we have so much heterogeneity in the HMO market, in particular.

However, there are possibly other ways to reward. You could use public acknowledgement or lower levels of regulation. So those might be two ways to mitigate that.

The second option basically speaks to the point

that some made that we really don't want to have an unlevel playing field between plans and providers, and said let's just put in place a minimum level of requirements on everyone. And then if we go beyond that Medicare would, as in many ways they do in the fee-for-service program now, assist plans and providers and then also reward them in any further quality improvement efforts.

So option two reads, all plans and providers should be required to meet basic quality requirements. Medicare should reward plans and providers whose voluntary efforts exceed minimal requirements.

The implications of this recommendation are several and depends, in many ways, on how you would define basic quality requirements. If, as the discussion went in some ways yesterday, you would define those as quality assurance requirements, it could imply that you would want to repeal the quality improvement requirements that are currently on Medicare+Choice plans and might affect the fee-for-service efforts to actually put in place some minimal quality improvement standards on providers.

If you were to suggest there would be some basic level of quality improvement requirements perhaps just

process and structure requirements, but not all this large number of measures or type of measure and specificity of measures. Then it's a less of a -- for want of better words -- dramatic change from what's currently being done in Medicare+Choice as well as in the fee-for-service program.

So it would probably imply pulling back on many of the requirement measurement efforts in Medicare and perhaps fee-for-service doing pretty much what it's doing and allowing room for them to put in place quality improvement process and structure requirements.

Those are the two options.

MR. HACKBARTH: Comments on those options?

DR. WAKEFIELD: On this recommendation, since it's up there right now. Actually I had a question about -- and you addressed it. But it makes me wonder, I guess, if this one were to pass, if we should have some discussion in the text about what we mean by basic quality requirements. Because the first thing I thought was well, what do we mean by basic quality requirements? Are we talking about QA and/or QI? And basic in both areas or not? So in other words, if this passes I think there's got to be some definitions drawn in the text.

Secondly, am I understanding this correctly that what this could do is to decrease the QI requirements on M+C now down to, if you'll forgive that, but down to what we've got existing in fee-for-service now? As opposed to trying to move QI forward and bringing fee-for-service up. Now that's a really crude way of describing this. I apologize. I wasn't in the discussion yesterday.

MS. MILGATE: In terms of requirements I guess I would say at least that's how I would interpret it. But there was a lot of discussion yesterday on ways to reward providers and plans to actually do more than that. But in terms of requirements, that would be my interpretation, that yes you would be taking the level of actual standards down to -- if people don't agree, I'm perfectly happy to hear otherwise.

DR. ROWE: I thought I heard something different than that yesterday. What I thought I heard -- I mean, we all heard a lot of stuff. One of the things I heard, although it may not have been the consensus, was that recognizing the differences in the inherent capability of different structures, that there would be a different requirement for the basic quality program in the different

elements of the Medicare program, Medicare+Choice, traditional Medicare or whatever.

And that above that, all of them should be rewarded for innovation in advance. But that we wouldn't want to put requirements on one that it couldn't reach because it just didn't have the structure or the network or something like that. So that's what I thought were going for.

MR. HACKBARTH: That's option one was designed to capture that point.

MS. MILGATE: Yes, I was just answering option two.

DR. ROWE: I heard something different than you did.

MS. MILGATE: I think what you just said was said. I don't think it was said by those that felt more comfortable with this option.

DR. NELSON: I really hate to get into the business of rewriting this, but I think you separated the concepts in a way that there's some mutual exclusivity that wasn't reflected in yesterday's discussion. Option two can be fixed very easily to incorporate the idea of different

capabilities with just adding a little bit of additional words.

Working from option two and saying all plans and providers should be required to meet basic quality requirements, taking into account the capabilities of providers and plans, which you use in option one. So that variable capability is acknowledged, and should be.

And then the second part says Medicare should reward plans and providers whose voluntary -- and I'd add quality improvement efforts -- exceed minimum requirements. Because you've already talked about quality assurance in the first sentence.

So a combination of one and two, in my view, is necessary in order to accommodate the discussion that we had yesterday.

MR. HACKBARTH: I think I may be the instigator of this problem so let me just take a minute and try to explain, hopefully more clearly than yesterday, my thinking on this. Number one, I think it's clear that by design the quality improvement capabilities of some organizations are different, if not weaker, than others. In fact, there are some types of plans that are designed to take the

responsibility for decisionmaking away from the health plan and put it in the hands of individual clinicians and their patients. That's their intention. Plan doesn't control quality, doesn't control clinical decisionmaking.

A second important point from my perspective is that plan level quality information -- I'm thinking now from the perspective of a beneficiary trying to choose among the myriad options that they might face -- plan level quality information is inherently, I think, of very limited value to that decisionmaker when you're talking about plans that have virtually all-inclusive networks.

If you have a plan that encompasses all providers, what Jack referred to yesterday as managed care lite, the differences among plans and their quality are not going to be very great because they're basically using the same providers. It tends to wash out differences. So if we're thinking in terms of helping beneficiaries make decisions, these big network plans reduce the utility of plan level activity.

I think the plan level requirements also have a major cost from a provider perspective. Put yourself in the position of a provider that contracts with four or five

different health plans that now have quality improvement mandates that they're all tackling in a different way. And so they've got this bureaucracy, this regulatory burden if you will that's created by trying to help different plans meet mandated quality improvement requirements when they participate in multiple networks.

This, to me, is grossly inefficient. And as I say, it's of little added value to the beneficiary.

Finally, as I said yesterday, it seems really perverse to me to say well, if you have greater capabilities we're going to put more weight on your back because what that does is create an incentive for people to say well, I'm going to disavow responsibility. I don't want to develop capabilities to improve quality because they're just going to make me carry more weight.

So I was the one who was saying let's get out of this. Oh, we're going to be flexible based on plan capabilities because I think that it's perverse in the incentives it creates and the value to beneficiaries is minimal and it's really burdensome to providers that participate in multiple networks.

And on top of all of that, I think we know this is

still an embryonic field, quality improvement. It is rife with problems. Measurement problems, risk adjustment problems, how you engage clinicians meaningfully in quality improvement. I think that mandates, especially uniform mandates or even variable mandates, are just going to get us in a peck of trouble here.

And so I was the one who said yes, maybe let's back away from current law and say in recognition of the competitive playing field problems, in recognition of the inherent difficulty of this field, we ought to be trying to support, reward, encourage quality improvements by providers, whether they're in fee-for-service Medicare or in a managed care plan of whatever type.

DR. NEWHOUSE: I'm sympathetic to that view, and I kind of started where Mary started, that recommendation one has a quality improvement flavor about it and recommendation two or option two has a quality assurance feel about it. I think we would help ourselves to distinguish those. I'm with Glenn that quality improvement, it seems to me, it will be successful if it's voluntary or comes from within the organization, professional motivation and so forth.

Mandating quality improvement, I'm not sure is

going to be very successful. Maybe there's some evidence on that. I don't know.

So that would be the general approach I would take with quality improvement. I don't know if that rises to a recommendation or not.

In the quality assurance front, insofar as this is concerning plans, I had a couple of points. First of all, it seems to me the plans value added is likely to be greatest in the coordination across providers area. That the plan has kind of the least leverage within provider, but the handoffs and so forth is where it could potentially add value.

Secondly, I would set the bar for the plan, if we're going to do this then, I mean minimal requirements is fine but I would like to compare it against traditional Medicare. It seems to me that that's the right -- at least if we're talking about value added -- that's the right comparison as opposed to an abstract standard. But there's some minimum abstract standard also, that really should be there.

DR. ROWE: I think we're backing off a little too far. I'll take my health plan CEO hat off and put my

geriatrician hat on here for a minute. I think that, as we said yesterday, because of the lack of incentive from employers -- but we'll get to that change, maybe we'll get to that in a few minutes -- there's not been the development of quality oriented products, if you will, in the commercial managed care marketplace.

Medicare has a great opportunity to really incentivize, foster innovation, reward it. I think that's great. But I do think that -- and notwithstanding the hassles of managed care lite and physicians having to report to four different managed care plans and four different times of the year and four different HEDIS variant measures, et cetera -- and we're trying to work on that, by the way. The industry is trying to, with NCQA, is trying to develop an approach to that.

Notwithstanding that, I think that the promise of managed care is higher quality at lower cost, more prevention, et cetera. And that's what M+C should be. And we should be held to some higher quality standard than traditional Medicare because that is the promise.

I don't know where to go. When I'm listening to you and Joe, and I know it makes sense, it's logical, it

just sounds like backing up a little too far for me and I'd like to have some hurdle there for quality as the standard in the M+C, recognizing innovation and reward.

MR. HACKBARTH: Is the only way to show support and leadership a mandate, I guess is what it boils down to? Are there other ways that we can show leadership?

I agree that Medicare should be a leader in this. Do we have tools in our box other than well, let's require it?

DR. ROWE: I understand what you're saying and I think you understand what I'm saying. If there's enough innovation there and if there's a meaningful reward, then we'll get the result, I think. But I'm concerned that there might not be. And the purely voluntary piece of it scares me unless there's a real incentive because we've seen purely voluntary not work in the absence of incentives.

MS. NEWPORT: I confess, like others, to be a little startled with the idea of backing off the M+C standards, frankly. That wasn't what I thought was happening in the discussion yesterday.

What I wanted to convey through our report there was an interest in addressing some of the issues also on the

fee-for-service side right-sizing the standards. I think Bob said it best yesterday, which was not seek a minimum of best practices but incentivize, encourage an atmosphere where more dynamic quality improvement standards were put in place.

So while the intuitive to that is a base, I believe, I was very concerned with -- and Mary can probably speak better to this, that on the fee-for-service side, which is where the bulk of our Medicare beneficiaries are, that as a purchaser Medicare needed to seek a method to export best practices or measure. I think Alice said that yesterday. Measure or confirm that indeed best practices were out in the fee-for-service area as well. Intuitively they probably are to some extent.

But if you're going to be comparing or provide tools for beneficiaries to compare where they should be and be assured that they're getting good quality and the government is paying or they are paying for good quality, that's what we're trying to do. So it was taking this, evolving it into a higher form of quality for a very large purchaser.

So I just don't want to convey the message that

we're somehow seeking to take a backward step on this, but encouraging and incentivizing. I don't know how we bridge this at this point, but that's my view. I really think what Bob said yesterday was what I was very comfortable with.

MR. MULLER: I'd like to make my effort at the exegesis of these quality of care standards. Just consistent with what all four of you who have spoken have said. In between things like conditions of participation and accreditation and so forth, there's a basic level that some entities have gone through. Obviously, the more organized entities have already been doing it for many years. And even the Joint Commission has tried to move beyond the QA into CQI over the course of the last four or five years.

So I share with the comments that have been made so far that we should not back off of those. I think that would be going in the wrong direction. That's been hard to implement over a long period of time that successive change. Providers have gotten used to that, so I think it makes sense to keep going in that direction.

So my sense of both what we should be saying, and what we said yesterday, and what I hear the four people

saying, is we want to be encouraging best practice. We want to encourage that, in part, by rewarding it. I think recommendation one, in my view, captures that better than recommendation two.

I don't like words like minimal and basic. First of all, it should be basic twice or minimal twice, but most people don't like to vote for minimal and quality. It scares people to just have minimal quality. They want a little higher threshold than minimal.

Whether one wants to use Joe's words from yesterday of quality assurance, or whether that's too much technospeak, it probably is for most beneficiaries. They don't understand the difference between QA and CQI.

But my sense is more with recommendation one, reward for improvement. A sense of not backing off where we are already. On the other hand, as Joe has said, let's not mandate beyond that but reward and encourage beyond where we are right now. So I think one captures that better.

Again, the minimal wordsmithing I would do on one is some people don't like to talk about uneven quality. It scares them. So probably differential might be a better way of discussing that, rather than uneven. And then I think we

should be making a bold statement about trying to really improve the quality of care in the basic Medicare program but understanding that that comes from voluntary efforts at this time, rather than through mandates.

DR. ROWE: So you'd take the second sentence of option two and add it to option one?

MR. MULLER: No. I happen to think one captures it reasonably -- the way I'm reading the second sentence of one and two, I'm reading them reasonably equivalent. I want to get rid of minimal and I want to get rid of moving backwards. Going forward should come through rewarding rather than through mandates.

DR. ROWE: That's what I'm looking for.

MR. HACKBARTH: Let me pick up on the compensation versus reward. To me, at least, compensation sounds exclusively like monetary payment. In an abstract sense maybe that's what you want to do, but I don't know how it could ever practically be done. Reward is more flexible and it could be we give them a seal of high quality that is then marketed to beneficiaries. Between those two words I would certainly prefer reward.

DR. ROWE: The problem is we don't want to reward

them just for higher costs. We went to reward them for higher quality. So the wording here in one kind of suggests higher costs.

MR. HACKBARTH: So that's where you were going, take this sentence from number two and move it over.

DR. NEWHOUSE: Glenn, maybe we should drop the conditional of this and just say, Medicare should reward plans and providers who demonstrate superior quality, or something like that.

MR. HACKBARTH: And add that onto the end of option one?

DR. NEWHOUSE: Implied in the first sentence is that the capabilities are uneven. Why are we mentioning the first sentence if the capabilities are equal?

MR. MULLER: Joe, part of what we discussed at great length yesterday is a lot of these capabilities are still in process rather than outcome because of all of the arguments over why we can't measure outcomes very well right now. So we are still at a state where we want to reward innovation -- to use Alan's words -- we want to reward innovation in quality improvement processes, which hopefully will lead to improvements in outcomes.

But I think most anybody concedes the evidence on that is hard to marshal at this point.

DR. NEWHOUSE: Indeed, I'm nervous that rewarding some dimensions, as I said yesterday, may result in give-ups on other dimensions that leaves us unbalanced and no better off. But that's an empirical issue.

MR. HACKBARTH: Let me see if I can crystallize where I think we are in terms of language in option one. What I hear people moving towards is something like the following. The first sentence as is, take into account the varying capabilities. And then --

DR. NELSON: Glenn, try and do it so we don't start out with a caveat. I'd like to start out with a strong statement that support quality improvement or quality assurance or both. We start out with a caveat that sort of says if.

DR. NEWHOUSE: What if the first sentence is Medicare should reward plans and providers that incur additional costs in QI efforts.

MS. RAPHAEL: The Secretary should apply quality improvement standards [inaudible].

DR. BRAUN: I'd really like to come back to Alan's

original thing. I think I'm next on that list.

I really like the idea of differentiating between quality assurance and quality improvement. I think that's important. And option two really does that if we leave the first sentence in. And in the second sentence put Medicare should reward quality improvement efforts that exceed minimal requirements.

If we take the word voluntary out, then you could have it either voluntary or non-voluntary. At the moment, it's not voluntary for health plans. But I think it leaves us a little freer than just rewarding the voluntary ones, to reward either ones. But I think we want to reward quality improvement but we want to keep in place that there is quality assurance.

And it seems to me that we're heading for a goal of high quality and there are going to be different ways for different groups to get there, but at some point what now are basic quality requirements could be raised as we find ways that everybody can meet certain things.

DR. ROWE: Would you accept, Bea, getting rid of the word minimal and having standard requirements? That's one of Ralph's concerns, that minimal really sounds --

DR. BRAUN: Well, exceed requirements maybe. Again, if you take voluntary out, take minimal out so that we're allowing -- I mean, we're going to depend on how important they are.

MR. HACKBARTH: Bea, what about the reference in option one to varying capabilities? Remember that the question we were asked by Congress is should there be uniform requirements or should we take into account varying capabilities. I know that's a paraphrase.

DR. BRAUN: I think, again, we're talking about two different things, if we're talking about quality improvement or quality assurance. And I think they keep getting mixed up. They keep getting mixed up in this chapter.

I think easily we could add that on to that first -- or put it first, taking into account capabilities of different providers and plans, all plans and providers should be required to meet basic quality requirements. That could be added on.

But I think there are basic quality requirements that should be met across the board regardless. And then the quality improvement standards will differ, depending on

the ability of the providers.

MR. HACKBARTH: We need to get to a vote here.

MR. FEEZOR: Bea actually has raised a concern that I had. I think we're trying to play chess on three levels of the chessboard here. I think the quality assurance that Bea talks to, and I think that Joe talked about, is really more what we think ought to be available, information that ought to be available to all enrollee, all Medicare enrollees, sort of certain basics. I think if we think along that level, information that might go to the patient if you will, on some sort of quality assurance or accountability, then there is I think the issue of quality or accountability that is needed from Medicare as a purchaser, regardless of what venue.

And then there is perhaps a third sort of quality assurance that we try to get that is to CMS as a regulator to make sure that within the Medicare+Choice and some other arrangements that, in fact, there is at least assurances that some of the perversities of the incentives that might be within those plans do not occur.

So I think if we think along those lines, I think it leads us back to what Bea, and I think Joe, were talking

about. We need to talk about some minimal level that may be constantly ratcheted up that goes for all enrollees, information on quality that helps them make decisions. And then that, in terms of the sort of quality improvement, which quite honestly many of our accrediting institutes that we referenced yesterday really are using, as Ralph said, because there are not good outcomes measurements. So we sort of say well, if you're making efforts towards quality improvements.

So I agree and I think taking the diverse starting points of providers and plans, the sentence, and perhaps some of Bea's comments, drafting that onto option two may get us a little closer to where I think we need to go.

MR. MULLER: Let me then suggest a combination of the two. That you take sentence one from option two. All plans and providers should be required to meet -- I'll leave the word basic in -- quality requirements. And then you go to option one. The Secretary should take into account the varying capabilities. I think that varying capabilities concept is very important to have. And then if this results in a differential level of quality requirements, Medicare should reward -- to use Glenn's phrase -- plans and

providers who -- we have to work on the syntax here because we don't want to reward people for additional costs. We want to reward people for quality efforts that may lead --

MR. HACKBARTH: Ralph, along those lines, if we're trying to make this distinction between basic quality assurance and quality improvement what we may want to do is make that explicit in the second sentence, which would be the carryover from option one. So we should say the Secretary should take into account varying capabilities when developing and applying improvement standards that go above these basic minimum requirements.

So we're making this contrast between sentence one and two.

DR. ROSS: Can I offer a caution here. Let's not try to cram it all into the recommendation. I think it's implied there that quality assurance for all, quality improvement where we can, taking into account varying capabilities, rewarding those who incur additional costs, meeting those [inaudible] additional steps.

MS. BURKE: I have a concern about reference to basically financing additional costs because we will create a new industry in finding additional costs. So I think the

issue is not additional costs. The issue is rewarding effort. So I'd strike additional cost.

DR. REISCHAUER: This is my attempt to probably pack too much into one recommendation. All plans and providers should be required to meet basic quality assurance standards -- and then maybe or maybe not we could say -- that should be periodically strengthened, reflecting the various capabilities of different organizations. Medicare should reward plans and providers whose efforts to improve quality lead to significantly higher -- I don't want to say quality again. That's another aspect but we haven't talked about that at all. And we're using the word reward, so we aren't talking about cash necessarily.

MS. NEWPORT: We have a Rosenblatt proposal over here.

MS. ROSENBLATT: It's very similar to option two. Just adds a couple of words. All plans and providers should be required to meet basic quality requirements which take into account the capabilities of providers and plans. Medicare should reward plans and providers whose quality improvement efforts exceed requirements.

DR. REISCHAUER: What that says, Alice, whose efforts exceed quality improvement requirements or standards, or whatever you said. That's if you do more than is in the law now you should be rewarded. I think the question was, in some sense, what's in the law now. It's reasonable to ask, the differential.

DR. ROWE: She has that in the first sentence. Read it again, Alice.

MS. ROSENBLATT: All plans and providers should be required to meet basic quality requirements which take into account the capabilities of providers and plans. Medicare should reward plans and providers --

DR. REISCHAUER: What you just said then would be the quality assurance could be different. That's Jack's --

DR. NELSON: What we're saying is that Medicare+Choice has a higher level of quality assurance currently under law than can be applied to traditional Medicare because they don't have the capacity to know what percentage of patients are having flu injections and so forth. The HEDIS requirements are different.

So the taking into account the capabilities of providers and plans has to be applied to the basic quality

requirements, just as Alice recommends it.

Then there's the second. Because Congress originally asked us should the requirements that Medicare+Choice struggles under be also applied to traditional Medicare. And we say yes, if they have the capability. So that's where that qualifier has to be.

DR. REISCHAUER: Which we've said in the text.

DR. NELSON: But they may achieve it. So then the second sentence identifies the importance of continuing to try and improve that capability.

DR. STOWERS: Alan, I'd like to take it a step further. I still think that if we just took the first sentence out of option two, like Ralph is talking about, the first sentence out of option one. That way we are still saying that regardless of the type of plan, the Medicare beneficiary is going to be assured a basic level of care, regardless of what kind of plan they're in. And that we should take into account -- and I like it because it has quality improvement in it.

And then go back to the last sentence of option number two, reward plans and providers for efforts that exceed the minimum requirements.

So I think that way we still have a basic quality assurance for the entire program. We recognize different improvement standard ability, quality improvement capabilities, and there's a reward to doing that. So I think that would cover everything that we're talking about and still hold a high standard for the program.

DR. NEWHOUSE: I have two problems, the first of which Bob Reischauer did get around, which is the first sentence of one talks about quality improvement standards. I'm not sure there are quality improvement standards. There's various kinds of quality improvement efforts that go on. There's kind of minimal quality assurance standards, in my view, at least as I understand this.

The second is I'm nervous about -- although I was the guy that introduced rewarding, I think, yesterday or the notion that it was an incentive rather than a requirement. I'm very concerned about rewarding just anything that happens to appear out there without having a clue about what it's buying us. Our language seems to allow for that.

That is to say, it seems to just reward anything that somebody labels as a quality improvement effort.

DR. ROWE: So you want something like, advances in

the quality of care --

DR. NEWHOUSE: That can be demonstrated to achieve an important or worthwhile advance in the quality of care.

DR. ROWE: You want outcome, not process.

DR. NEWHOUSE: Well, if process -- if we know process links to outcome from other data, I'd be willing to buy process. I've just got to know that it's worth the money I'm spending to do this.

MS. BURKE: I just said to Ralph, this is just like sitting in a Ways and Means Finance Committee conference, just as circuitous. Brings back a lot of bad memories.

DR. ROSS: Let me offer one more unpalatable alternative. Given the circuitous discussion, which I don't see getting to closure here, that we bring this back to you in December. We have a statutory deadline that is prior to that, but I think we should be more concerned about getting to the right recommendation than in meeting a particular deadline. There's not a policy action immediately pending on receipt of this report.

MR. HACKBARTH: I think it's a little difficult, or it's a little difficult for me to follow the varying

rewrites of this. I think we would benefit from having staff try to clean it up and come back with a specific proposal.

It might be worthwhile, though, Murray to try to do at least part of it on e-mail before the meeting, so that we don't have to sort of pick it up cold again at the next meeting. I would like to come back and be ready within five minutes to vote as the first two. Does that make sense to people?

DR. ROWE: Glenn, let me make a suggestion. I believe we are prisoner of our own process here, to some degree. We are trying to get several specific and different ideas and principles into a kind of two sentence recommendation. We may get there better if our colleagues are given some flexibility to write something which is a little more detailed and says with respect to the issue of quality in Medicare, the Commission identifies the following principles or something.

There are four or five ideas that are not that much in conflict that we just can't quite seem to get into this format that we're using. So we might try a little bit different format.

MR. HACKBARTH: I think it's worthwhile struggling with this one to try to find a consensus. I certainly wouldn't want to convey the message that I am uninterested in quality or I don't think that Medicare should be a leader in quality. So I'm really reticent to vote no. I take seriously what Sheila and others have said about backing off from current law.

So I think it's worth the struggle to see if we can come up with something that everybody can agree to.

Please, when you get the e-mail, if you will respond to that, probably the quicker we can do this while it's fresh in people's minds the better.

MR. MULLER: I'd like to make one brief comment on the rewarding or compensating. I don't think it should be reduced just to a kind of financial compensation issue. I think part of the discussion we had yesterday, at least Joe and I were pushing, was we want something that's more comparable with what came with the cardiac data in New York state which encouraged improvement of quality versus the kind of mortality data which caused everybody to say you don't know how to do risk adjustment and so forth.

So part of this is you want to have quality

improvement processes, we want to be innovative of that and encourage people to improve the quality of care, as opposed to being penalized for doing so. So it's not just a cause issue. It's also people being scared of getting into these processes because they think the wrong message is being put forth.

That was really, I think, part of the sense that I hope doesn't get lost as you rewrite this.

DR. WAKEFIELD: I appreciate how difficult this must be, that this an end. I wasn't part of yesterday's discussion so maybe I'm coming fresh to it and I'm happy to have another three hours of discussion about this topic. I won't encourage that except to say that this comes down to me in sort of a personal way. And why I think it is important to do just what you're suggesting, Glenn, and try and get this as close to right as we think we can.

Using my own little 82-year-old mother, who's in fee-for-service, as an example of a Medicare beneficiary, we think about cost of quality improvement. I also think about the fact that she's had three different procedures in the last three years that our Medicare program has paid for. One, carpal tunnel surgery, first done on the wrong hand.

Secondly, steroid injection, different provider, different hospital --

DR. ROWE: North Dakota?

DR. WAKEFIELD: I wouldn't say where, except I'll say this much -- no, not North Dakota.

[Laughter.]

DR. WAKEFIELD: And the second procedure, a steroid injection under fluoro in an outpatient department, wrong hip. There's a lot that we've got to -- and Medicare paid twice for two different procedures.

So true enough, we may not be able to quantify right now what it is a QI brings to us, but I can sure quantify what happens when we don't have systems of care in place. And I'll be very strong to say I'm not talking about poor providers. I'm talking about systems of care that could have been in place and preventing both of those things from happening.

So it's a really important struggle. She's just an n of one, but I wouldn't wish it on anybody else. So I'm glad we're going to come back to this one more time.

MR. HACKBARTH: That's a good concluding note.

DR. ROWE: Glenn, I'd like to comment on this.

Let me just pass this around, if I might.

MR. HACKBARTH: Sheila is raising an important point. We did have other recommendations in this particular report. My recollection was that there was not much controversy about them. We probably ought to handle them all as a package when we vote, and not do it separately.

MS. MILGATE: There's some link between how we do one and the back of it, so that's probably good.

MR. HACKBARTH: Okay, Jack, do you want to describe the piece that you passed out?

DR. ROWE: I mentioned yesterday that there hadn't been much in the way of activity from the plan sponsors with respect to requiring quality or paying for quality. This article by Mil Freudenheim appeared in today's New York Times describing a consortium of sponsors in Florida, Lockheed-Martin, Walt Disney World and Universal Studios, who are going to reward doctors and hospitals presumably based on their compliance with AHRQ standards for treating certain diseases.

This is very encouraging. These are obviously self-funded plans that are doing this. And it notes something else that is being done in New York with Empire

Blue Cross and a number of large sponsors.

Alice mentioned something about Wellpoint recently had a lot o press. And there have been other -- US Healthcare years ago actually started doing this in Philadelphia. So there are a number of different initiatives but this is encouraging that it's happening now and maybe there will be more like this.

Having said that there wasn't much of this, I wanted to bring this to people's attention. Thank you.

MR. HACKBARTH: Thanks, Jack. Thank you, Mary and Karen.

David, you're next up. We have some carryover business about the regulatory burden recommendations.

MR. GLASS: Everyone should have a new package of seven recommendations in it since we simplified this by getting rid of one yesterday. We just want to talk about recommendation two and three which we rewrote in accordance with your discussion yesterday.

Recommendation two we changed by adding the written guidance explicitly. We also added the part about they should not be required to refund related payments if the guidance is later found to be in error.

MR. MULLER: Glenn, I think this reflected a lot of the conversation yesterday. I just want to make the simple point that they're not going to provide written guidance no matter what we tell them to do, because most of this happens in real time. It's oral, 99.9 percent of it's oral. I feel there should be written guidance but we shouldn't pretend they're going to do very much of this, and the most we require it, even the one-tenth of 1 percent won't happen.

DR. ROWE: They might do it on e-mail. That would count as written.

MR. MULLER: So that in some sense I would like to offer a different -- given that by and large these kind of requests for guidance come in real time on the telephone between the staff and the carrier's staff. So I'm not as worried about the oral guidance as maybe Jack's comments indicated yesterday because you can at least write down your version of the oral guidance. But I'm just worried that written guidance --

DR. ROWE: It's not binding.

MR. MULLER: I know it's not binding. It won't be as binding. But the point is, the written guidance is just

never going to happen.

DR. REISCHAUER: The airlines tape and banks tape conversations. I would insert the word timely into this thing, if we're going to move forward with this recommendation.

DR. ROWE: Just say, written or electronic. I really think e-mail -- they're sitting there at the computer. They're on the phone with the doctor and they say, okay, what's your e-mail address? I will e-mail you this -- bam.

MR. HACKBARTH: We'd add the notion of electronic written or electronic guidance, and timely.

MR. GLASS: Do you want us to put that in the text or just --

MS. BURKE: Yes.

MR. GLASS: But you want timely in here, right?

MR. MULLER: Yes.

MR. HACKBARTH: Timely definitely needs to be in the recommendation. Electronic can be in the text. I don't think that needs to be in the recommendation.

Any other comments about number two?

MR. GLASS: Okay, number three --

MR. HACKBARTH: Why don't we vote on it? All opposed to recommendation number two?

All in favor?

Abstain?

Okay.

On number one, did we vote?

MR. GLASS: I thought you voted that yesterday. You did vote yesterday, yes. You don't have to vote again.

Number three we changed a little more substantially, and I think this is what the Commission was talking about. CMS should explore ways to reduce routine administrative requirements for plans and providers that demonstrate sustained good performance. It was to change the tone of the program we would move away from the punitive.

MR. HACKBARTH: Okay. All opposed?

All in favor?

Abstain?

Is that it?

MR. GLASS: I think that's it, yes.

MR. HACKBARTH: Thank you.

Next up, what's next for Medicare+Choice?

DR. HARRISON: Today we have assorted topics on Medicare+Choice. The panel you see here will present four different topics related to Medicare+Choice that will give you a chance to see where we are on these Medicare+Choice issues. We don't have any draft recommendations to present today. Instead we will listen to your discussions then come back in December with Medicare+Choice draft recommendations.

Susanne will start with a quick look at the benefits that will be offered by Medicare+Choice plans for 2002. Next Dan will give you an update on the current status and next steps for risk adjusting payments to the plans. And Ariel Winter, in his MedPAC debut, will follow with a report on the GME carve-out from Medicare+Choice payment rates. Finally, I will take a look at the issue of using competitive bidding to set payment rates.

Susanne?

DR. SEAGRAVE: Good morning. At the October meeting, the Commission expressed some interest in getting information about the 2002 Medicare+Choice benefit packages. I am here today to present some preliminary findings of our analysis. I want to stress that these are very preliminary.

So far staff have analyzed the benefit package

along two dimensions: the premiums that plans are charging and the outpatient prescription drug benefits that plans are offering. We have not yet looked at hospital coverage and inpatient coverage and those sorts of issues.

In the first slide we present national trends from 1999 to 2002 in beneficiaries' access to plans with selected benefits. I think it's fair to say in general that access to these types of benefits have declined from 1999 to 2002. I wanted to note here that we are looking at all Medicare+Choice plans except for the private fee-for-service plans. I'll allude to that more in a minute. As you can see, from 1999 to 2002 access to zero premium plans in particular declined a lot. It fell by about half, in fact.

You can see in this slide that beneficiaries who live in urban areas still have modest access to many of these types of benefits. However, in rural areas I think it's fair to say that access is close to none in rural areas. But I wanted to point out that in fact almost 30 percent of beneficiaries in urban areas have access to a zero premium plan that also offers a drug benefit.

As you can see, there's also a continuing disparity in access between floor and non-floor counties.

By floor counties I mean those counties in which the Medicare+Choice base payment rate is either $475 or $525. The non-floor counties include all other counties.

DR. NEWHOUSE: Susanne, can I ask, these are percentages of plans or percentages of beneficiaries?

DR. SEAGRAVE:

These are percentages of beneficiaries.

DR. NEWHOUSE: So they're beneficiary weighted.

DR. SEAGRAVE: Yes. We see that access to zero premium in prescription drug benefits in floor counties still lag behind the access in non-floor counties. I wanted to point out here again that we have excluded the private fee-for-service plans because we typically do exclude them in this kind of analysis. But even if we included them, the private fee-for-service plans do not have zero premiums. In fact I think one of the plans has a $78 premium and the other one has an $89 premium, and neither plan offers prescription drug benefits.

In the previous three slides I've given you sort of a 30,000-foot overview looking at whether a plan offers a prescription drug benefit or not, and other whether it offers a zero premium or not. We haven't gotten very far in

looking more in depth at these benefits, but I wanted to just give you a flavor, more sort of a qualitative flavor of what we have observed might be going on underneath the surface.

The first trend that we find is, obviously, that premiums are increasing. In fact if we look at all plans we find that the average premium in 2001 was about $23, and in 2002 will be about $35. If we limit our analysis to only those plans that charged a positive premium the average increases from $41 in 2001 to $58 in 2002. So that gives you a flavor of how much premiums are increasing.

Among plans that offer a prescription drug benefit, we examined them to see how that benefit might have been changing next year. Two general patterns that I just wanted to point out are emerging. First is that plans are increasing their copayments for outpatient prescription drugs, which I don't think is a big surprise to anyone. And the second trend that I particularly found interesting is that many of the plans are dropping their brand name drug coverage. They're continuing to offer generic drug coverage but are dropping the brand name coverage.

So those are some of our preliminary findings, and

if the Commissions like we will continue to come back with more findings.

MS. ROSENBLATT: Susanne, this is a great direction. I just have a suggestion. We heard from Paul Ginsburg yesterday morning on overall trends affecting under-65 non-Medicare population. I think it might be interesting to look at the trends that we're seeing in Medicare+Choice alongside of what trends are we seeing in the overall industry.

I think one analysis that I might be interested in, when you're talking about going from, I think you said $41 to $58, that's almost like what's happening to the employee portion of a total commercial premium rate. You're only see a piece of the total. So even though the percentage sounds very high, if you were to say, what's the total cost of the program if you added in the Medicare payment as well as that premium and then said, what's that percentage, and how does that percentage compare to the way we're seeing commercial premiums go up, I think you'd have a more apples to apples comparison.

DR. ROWE: Susanne, I think it would be helpful also if you can get these data, and I don't know whether you

can, to look at the proportion of the plans that are at the maximum-permitted premium, because unlike the situation in the commercial HMO or a plan where there is no statutory limit to what it could go up to.

As I said at a prior meeting, I think that a lot of the plans that stayed in Medicare+Choice did so by maxing out on the permitted premium in their area, and they're kind of on the cliff of dropping out of the program because they've got nowhere else to go with respect to increasing revenues. It would be interesting to know what proportion of the plans are at the maximum compared to what proportion were at the maximum before.

In addition, one of the factors that that would provide insight in is, while there has been this increase from $41 to $58, part of that population could not increase; they were already at the maximum, so they didn't increase. So that the proportion of the plans that increased, as opposed to the ones that could increase is -- the denominator should be the ones that were not at the maximum -- would also be an interesting number. So those would be, if you have those data, two suggestions.

DR. HARRISON: Jack, the data there is a little

strange because it's not that there's a maximum premium. There's a maximum of copays plus premium. I'm not quite sure how we would find that, because if you were going to do an ACR proposal my guess is you would max that out and then charge a premium above that for supplemental benefits. I'm not quite sure how you'd tease that out otherwise.

DR. ROWE: The plans have the data.

DR. HARRISON: But they still make choices along the premium-copay continuum, and I'm not quite sure how that would --

MS. NEWPORT: Jack, I think he's right. It would be difficult. It's not that you exhaust your premium and then go to the other copays. You build it differently so that the max on your premium is something that, depending on your market, you may never theoretically go to it.

DR. ROWE: I understand, but I guess I was looking for those that felt they don't have any room.

DR. HARRISON: Now there is an issue there and it's a geographic issue, in that plans in New York, for instance, may -- the out-of-pocket maximum for beneficiaries is calculated on a national average and that does not vary by area. So plans in New York may have a disadvantage

because if their patients have higher copays they're not going to be able to -- they may hit their cap faster. So that may be something we would want to look at.

MR. FEEZOR: These figures are fairly close to what we've observed within CalPERS in terms of our Medicare supplemental market. Susanne and the rest of the team, I don't know whether there's any -- I'm curious as to the non-availability of Medicare+Choice plans in urban counties where in fact there is a good HMO market, or there might be an HMO market.

In California we're looking -- there is very clearly an urban-rural issue, but there's also what I call the non-competitive health care markets where in fact choices are not available. It's an issue that I think that -- maybe it's unique to California, but when I think of Monterey County it's hard to think of that as a rural county, and yet that's one of the -- for instance, an area that we don't have choice. So I don't know whether you can find any anecdotal or information relative to why choices are not in some of the urban areas would be interesting.

MS. ROSENBLATT: I just want to pick up on what Jack said. I think there is an area of investigation there.

I'm not an expert on it, but there is somebody at Wellpoint I could put you in touch with. There's an actuary that really understands how the actuarial value of the out-of-pocket benefits goes into this. I think there is an interplay there that's worth considering.

MR. HACKBARTH: Okay, we should go ahead and move ahead to the next step. Who's up now?

DR. ZABINSKI: Today I'm going to talk about the status of risk adjustment in Medicare+Choice. Risk adjustment in the Medicare+Choice program has received considerable attention since the program was created, and today I'll discuss the status of that development. But before doing that I think it would be useful to review why risk adjustment itself is important.

Now the purpose of risk adjustment is to pay plans fairly for the expected cost of their enrollees if base payment rates are set properly. It's important to understand that fair payments can only occur if both the base rates and risk adjustment work properly. If both are accomplished, plans will not lose or gain based on whether they attract beneficiaries in good health or bad health. Instead they would compete on the basis of benefits and

services. Moreover, accurate payments for enrollees with serious conditions will give plans greater incentives to develop effective care management programs for them.

Effective risk adjustment also would allow CMS to avoid overpayments or underpayments in the aggregate. Under the demographic system that is currently in use, for example, plans are overpaid for healthy enrollees and underpaid for those in poor health. Consequently, the Medicare+Choice program would be underpaid or overpaid in the aggregate if health status for enrollees differs from the overall average.

Finally, effective risk adjustment is necessary to attain the Commission's recommendation from March 2001 of financial neutrality between Medicare+Choice and traditional Medicare. The intent of that recommendation was to make payments between the two sectors equal after accounting for risk differentials.

Now on to the idea of the status of risk adjustment. We're currently a long way from an effective risk adjustment system. Currently there's a blend of a demographic system that was in use before the Medicare+Choice program was established that's blended with

a system that uses the demographic data and diagnoses from hospital inpatient stays. It's the PIP DCG model. Neither of these models performs exceptionally.

Now CMS had intended to replace the blended system in 2004 with a multiple site system that uses demographics and all diagnoses from inpatient and outpatient and physician office encounters. But plans complained about the burden of collecting this full encounter data so the Secretary suspended the collection of the outpatient and physician data in May 2001.

Currently CMS is looking for an alternative that would not require plans to submit the full encounter data. But if the agency fails to develop an alternative, my understanding is that collection of the full encounter data will recommence in July 2002.

In any event, we believe that whatever the model that CMS ultimately develops should reflect a number of principles. Two of these principles are simply restatements of previous recommendations that the Commission has made. First is that risk adjustment should use diagnoses from multiple sites of care as quickly as feasible.

Second, payments in Medicare+Choice and

traditional Medicare should be equal after accounting for risk. The second recommendation is important because it indicates that risk adjustment should redistribute resources between Medicare+Choice and traditional Medicare.

For example, if Medicare+Choice enrollees are healthier on average than fee-for-service beneficiaries, payments per beneficiary should be lower in Medicare+Choice to the extent of the difference in the health status. Conversely, if Medicare+Choice enrollees are less healthy on average than fee-for-service beneficiaries, payments per enrollee should be higher in Medicare+Choice than traditional Medicare.

Now we've also identified three other principles that are not based on recommendations. First, simply that risk adjustment should be based on data that can be quantified and that both CMS and the plans can collect.

Second, we recognize that data collection is costly to plans, therefore the data collection should be pursued with respect to a principle that the cost of collecting the data should not be disproportionately higher than the benefits from paying more accurately.

Finally, risk adjustment should not have the

potential to distort clinical decisionmaking. For example, looking at the PIP DCG model that's currently in use, payments for enrollees with inpatient stays in the previous year are increased, but that model does not increase payments for enrollees if the only diagnoses is from outpatient system encounters. Some have argued that this gives plans incentives to hospitalize enrollees in situations where they might otherwise treat in outpatient settings. But I'd like to point out that CMS has implemented measures that make this issue somewhat irrelevant in practice.

Now this slide, we have two risk adjustment systems that are under consideration. Both are intended to reduce the burden of data collection on plans. Under option one, plans would submit primarily diagnoses from inpatient stays, but they would also submit a few diagnoses from outpatient encounters, but far fewer than what CMS would have had them submit under full encounter data. The plans would obtain the outpatient diagnoses from several sources, including claims-like encounter data, disease registries, lab data, and drug data. These data would then be applied to a multiple site model that CMS had considered before data

collection was suspended.

A second option would have plans submit full encounter data with the same amount of diagnoses they would have submitted if data collection was not suspended. However, the plans would submit far fewer variables. CMS had been asking plans to submit quite a few variables, but diagnoses, date of service, and enrollee ID are actually the only variables necessary to run a multiple site model.

Now when we compare these two options we found three interesting differences. First, option one may not yield financial neutrality with fee-for-service Medicare. This is because CMS would use fee-for-service claims to identify beneficiaries' diagnoses and estimate the costliness associated with each condition.

In option two, plans would identify their enrollees' diagnoses in an analogous way by using claims-like encounter data. But in option one, plans would use encounter data as well as data from several additional sources, such as drug data and disease registries.

Consequently, under option one plans would identify enrollees with conditions who could not be identified with claims data, so Medicare would pay more to

Medicare+Choice for those enrollees than it would if those enrollees had stayed in traditional Medicare.

Second, option one would disadvantage plans that do not have access to disease registries or drug data because they would be able to identify fewer enrollees with conditions that result in higher payment. This would not be a problem in option two because all plans would have the ability to submit encounter data.

Finally, option two has greater power for predicting enrollees' cost because it would use more diagnosis information to classify beneficiaries than would option one. And because option two can predict costs more accurately, payments would more accurately reflect enrollees' costs.

I'd just like to close by saying that today our intention was simply to bring commissioners up to date on the status of risk adjustment. No action on their part is necessary, but of course we welcome their thoughts and their comments on the topic.

MS. ROSENBLATT: My thought, first of all, is I'm really tired of risk adjustment. We've been dealing with risk adjustment since 1993 I think, and it's really sad that

we don't seem much further along today than we did back then.

I would like another option to be considered, if it's possible. One thing in the narrative struck me. I think you had a little table there that said, 6 percent of the claims exceed $25,000. First of all, let me say that the Blue Cross-Blue Shield Association would attempt to make data available for you to do risk adjustment studies, so you should -- and I think Scott knows who to contact. So I think it would be worthwhile to try to get some actual plan data and do some studies.

I think in doing those studies I think you should not only document the results but document data problems, because I think you're going to find lots of data problems. And actually having you experience those data problems and report on them would be helpful.

But I'd like to see some option explored that just looks at the tail to see what's going on. Because the experimentation that we've done at Wellpoint with risk adjustment, in order to get some of these methods, even methods that use ambulatory data, to give good regression coefficients we've had to chop off the tail. I just don't

think any of these really work very well, so why not do something that's very easy and that just focuses on the 10 percent of the claims that drive a lot of the dollars.

I also think it would be interesting to document, if you get data from different plans, are there plans that are showing that they have a better result than the average, or are there plans that are showing they have a worse result, what's the distribution? So I think just documenting where those all fall out --

DR. ZABINSKI: One question. I just want to make sure I understand when you say, better results, worse results. Are you saying --

MS. ROSENBLATT: Better than average health status versus worse than average health status.

DR. ZABINSKI: That's what I thought. Just wanted to confirm.

MR. HACKBARTH: Alice, when you say just focus on the tail, could you just explain a little bit more about how such a system --

MS. ROSENBLATT: I'm talking about something that would work like a reinsurance scheme where there would be a charge PMPM made to all the plans or something like that, to

fund a pool that would then be used to pay plans based on -- for plans that were capitated, capitated providers you'd need to develop a fee-for-service equivalent. But payment for large amount claims.

MR. HACKBARTH: And you'd charge a premium to the plans based on the Medicare experience and how prevalent those costs are in Medicare. If they have a healthy population they would never pay for the insurance and --

MS. ROSENBLATT: Right. The idea of it is that you're only submitting data on those few claims, as opposed to data on all enrollees.

DR. ROWE: I have two points. One minor point, Dan, is that on the top of page 3 of your document you have an interesting thing. It starts on page 2. You say, finally a risk adjustment system should not have the potential to distort clinical decisionmaking. The PIP DCG model, for example, pays more for enrollees who have had an inpatient stay. This provides an incentive for plans to hospitalize enrollees in situations they might otherwise treat in the outpatient setting.

First of all, I think it's physicians generally who hospitalize patients, not plans, and I think that that's

an important difference there. Secondly, unless you have some data to indicate that plans are hospitalizing beneficiaries unnecessarily, this is a relatively inflammatory statement and I don't think it adds anything to the general discussion. If you have evidence, you might put it in. If you don't have evidence you might drop this out or say, although there's no evidence to indicate this, there is a theoretical -- or something. But I would prefer if we had doctors hospitalizing people, not plans.

DR. ROSS: Jack, we'd all prefer that. We were actually restating a concern expressed by this very commission in previous reports. It refers to an incentive, not to an actuality, since only 10 percent of the payment depends on that system.

DR. ROWE: I know. It's just people will take that sentence out independent of the footnote and the other sentences I think. I'm just concerned.

But secondly, I think there's an almost Alice-in-Wonderland nature to this from one point of view. I'm not sure any of these statements are wrong, but I believe the Medicare+Choice program is not growing. In fact I believe it's shrinking. I believe there is a concern in some

quarters, including Congress, that it may not be adequately funded, and that some plans are dropping out based on that, or that's what they say the reason. I believe there is in fact some proposed legislation to change the funding. I believe that the beneficiaries in Medicare+Choice plans are generally felt still, although the gap is narrowing, to have a lower risk profile than in traditional Medicare.

Statements in here indicating that, of course we should pay based on the risk will in fact reduce the payments to the Medicare+Choice plans and increase the payments to traditional Medicare. For MedPAC to therefore, basically make the recommendation, which is in the body of what you've said and written that the M+C program should have reduced funding at a point in time when the rest of this is going on does make us seem a little out of touch, or out of the loop. I think that it might be helpful --

DR. REISCHAUER: You voted for it last year.

DR. ROWE: I understand. I'm just trying to put this in some -- make us relevant. We might have a statement saying that there is currently discussion about the proper level of funding in the Medicare+Choice program, or Congress is considering this, or the Secretary or CMS or somebody,

and that in a properly funded M+C program in balance with Medicare there should be allocation according to the risk, or something like that. But just to have it here, irrespective of anything that's going on in the environment, it just seems a little out of touch.

MR. HACKBARTH: What we're trying to do is define what a properly funded program is, and our definition of that is that it ought to be equal to traditional Medicare after risk adjustment, and then the cards fall where they may. So yes, there is a disconnect between what plans have said about their funding and what we've recommended. Apparently we just don't see eye to eye on a matter of principle.

DR. NEWHOUSE: Two comments. First on option one. By the time you got to the last page, Dan, option one seemed to have incorporated drug data, which I don't think is inherent in option one. But in any event, I am concerned about trying to use drug data in risk adjusting for several reasons. One is we don't have those data from traditional Medicare, and therefore, I don't know how we incorporate it into the weighing structure.

Second, I'm concerned about possibilities for

gaming with paying substantially, potentially a few thousand dollars more on the basis of some number of scripts.

My second comment goes to Alice's remarks about dealing with the tail, which I have never been a fan of. One for theoretical reasons, and one for empirical data, which I'm happy to share with people. The theoretical reason is it doesn't do anything about the incentives on the other end to try to cream the good risk.

The empirical data are from some work by John Chapman who studied 50,000 people in an IPA, and he looked at the group that was in the top 5 percent of spenders in year one, and the top 30 percent -- the top 5 percent being some approximation to the tail. Then he looked at what happened to them downstream and how much a plan would have earned if it had been able to get rid of some fraction of people in the top 5 percent, some people in the top 30 percent.

What he found was there wasn't all that much profit in getting rid of the top 5 percent. The profit was really in getting rid of the top 30 percent. The reason for that seemed to be that the top 5 percent had a lot of one-time only high costs. They regressed to the mean faster

than the top 30 percent, or the next level down where there was more chronic disease.

MR. FEEZOR: Joe, just a quick follow-up to your comment. Not having drug availability for the regular Medicare population, but certainly our examining the various risk adjustment indicators, the drug became a very powerful one in terms of within our population, so I wouldn't want to dismiss that altogether.

Just one other. Dan, following up on Alice's comments, we struggled with the data availability in a study that we did, just concluded last year in California. Given the fact that we have a significant number of different payment mechanisms, so we were very concerned about the availability of data and the quality of that data. I don't know whether you've seen that or not, but we'll make that available to you. It will probably be very helpful, because --

And then the final observation is, it may be helpful in looking at the concerns that various Medicare+Choice vendors have had about the data availability for risk adjustment, and it may be helpful as we examine those concerns to take into account those who are either

current players still in that market, or would like to be, versus those who in fact have made a corporate decision to in fact not be a part of that program any more.

MS. NEWPORT: For the new commissioners that haven't been punished with my diatribes on risk adjustment in prior years, theory is one thing. I think practical application and operational impact is quite another when you're trying to create a process where you can incentivize in a rationale way providers to participate in the program, and therefore provide a broader spectrum of benefits including drugs. This is where it really has fallen apart.

The whole genesis of suspending data collection in the outpatient sector was the overwhelming burden it was placing on providers and the plans to make sure and verify that they had the accurate data. And then not have those costs overwhelm the increased payment or the decreased payment in markets where your overall medical cost ratios couldn't be paid for by the revenue that was coming in from Medicare.

I think that's part of the problem. Yes, it sounds wonderful to risk adjust, and it sounds wonderful to say that this is a right-size of payment. But it is not

necessarily theoretically sustainable in a marketplace.

The concern I've always had with this is that in saying the average payment is too high or too low never seems to recognize the added value that is required for plans to bring to the table, which includes drugs, which has been of immense value across the board in improving quality, in improving the type of care, the continuity of care, and incenting them to, pre-risk adjustment, move to quality care management programs across the board, and incentivizing some products in addition to what we offer in terms of continuity of care, and diabetes programs, and management of folks with chronic heart disease.

So I think that part of the issue, and hopefully enveloping some of the things that have been said, is that I feel like we're kind of trying to continue to support a process that isn't working, has had a negative impact on plan entry, and contributed to plan exits to the program. I think that in some of the citations you have in the paper the plans have, in an attempt to create an outpatient data process for getting to risk adjustment, have said we should seek data from other sources including pharmaceutical data sources, not any one of which is supposed to be totally

effective.

But at least it is available and does give you an opportunity to get to the tail, as Alice says, and say, okay, here is a less perfect method for saying that the pricing of this or the payment for this is a little more accurate without then overburdening the system in terms of what we have to do to go forward with it.

And more important than anything else is the predictability of payment over time and saying to your provider partners, we can guarantee you a certain level of payment for the costs you've incurred that is predictable and right-size. Because this never has really recognized that this is a system of integrated providers and vendors and hospitals and sites of care that are variable in and or themselves. So we're paid and then we have to drive that payment accurately down to those folks that we contract with, and they deserve predictability. That's where this all comes together in a rather awkward situation.

So I think that whatever the final paper is needs to reflect some of the market realities and concerns, and some of the efforts, good faith efforts that Alice has suggested as well, to come up with this process of better

informed and leads to some better payment, but also makes sure the program continues. So this is not an easy area. It's not going to be an easy area. But I think we need to accommodate some of the realities of what is happening in the marketplace right now.

MR. HACKBARTH: Ariel, welcome.

MR. WINTER: Good morning. I will be discussing with you today the carve-outs of medical education payments for Medicare+Choice rates. First I will explain how plans are paid, and discuss the impact of the carve-out on plans and teaching hospitals. Then I will discuss a potential issue the Commission may wish to consider, which is how to treat medical education payments under the principle of financial neutrality between Medicare+Choice and fee-for-service.

The 1997 Balanced Budget Act set up a very convoluted payment system for Medicare+Choice plans. The plans payment rate is based on the county in which an enrollee lives. The county rate is the highest of a floor rate, a 2 percent increase from the prior year's rate, also called the minimum update, and a blend of national and local rates which is subject to a budget neutrality test that is

intended to keep spending under the BBA's system in line with spending under the previous system.

The local rate is based on local fee-for-service spending minus medical education payments made to teaching hospitals, which is called the carve-out. This carve-out includes both direct graduate medical education payments and indirect medical education payments and is phased in over a five-year period. GME and IME are paid directly to teaching hospitals that serve Medicare+Choice enrollees. The national rate is simply the average of the local rates.

This slide has a table that shows the impact of the carve-outs on M+C payment rates by type of county in 2000. Across the top row of the table, the counties are divided by type of M+C payment they received into blend counties, 2 percent updates, and floors. Down the left side, the counties are divided by the level of GME payment.

You'll notice first that the 2 percent update counties in the center are not affected by the carve-out, which is somewhat surprising. This is because under the payment system set up by the BBA, the base that's used to calculate the 2 percent updates was not subject to the carve-out. And the carve-out was also not taken from the

floor rates. It was only taken from the base used to calculate the blended rates, which is why they're the only ones that are affected by the carve-out.

You can see that blend counties with above average GME payments experienced average reductions in payments of 3.5 percent, and blend counties with below average GME payments experienced average payment reductions of 2.5 percent in a year.

DR. REISCHAUER: This is only a fraction of what it would be in 100 percent.

MR. WINTER: Right, in 2000 it was 60 percent, in '01 it's 80 percent, and 2002 fully phased in at 100 percent.

DR. ROWE: It will be 5 percent.

MR. WINTER: One hundred in 2002. I think it will be actually 4 percent when it's fully phased in, 4 percent of total payments.

DR. ROSS: What Jack is getting at is if it's 3.5 percent in 2000 when that was at 60 percent, and when it goes to 100 that number would have been five.

MR. WINTER: That's right, exactly.

DR. ROWE: It would be like 3.5 and 5.5.

MR. WINTER: Here we have some examples of counties that were affected by the carve-out in 2000. The first set of counties are those with the largest reductions in total payments. Each county in that group experienced payment reductions of about $30 million in that year.

DR. ROWE: You mean plans in those counties. The counties didn't experience reductions.

MR. WINTER: Yes, plans in those counties. Thank you. The number after each county is the percent reduction in payments for plans in that county. Although the percent reductions are not very large, because each of these counties has many enrollees, the total payment reduction is significant.

The next set of counties are those with the largest percent reductions in payments. The first three counties listed, Pitt County, North Carolina, and Dodge and Olmsted Counties, Minnesota actually did not have plans, but I've decided to present them here to illustrate the highest -- the upper end of the range of reductions.

The last two counties listed, Monroe, New York and New Haven, Connecticut were the counties with the largest rate reductions that actually had M+C plans in 2000.

Now I'll talk a bit about the impact of the carve-out on teaching hospitals. In 2000, total medical education payments made to teaching hospitals for serving M+C enrollees were about equal to the money carved out of the M+C payments. Even though the entire system is roughly budget neutral, the counties with hospitals that received medical education payments for M+C enrollees were not always the same counties with plans that lost plan payments due to the carve-out.

Counties that gained medical education payments under the carve-out system were those with high use of teaching hospitals by M+C enrollees. Counties with plans that lost payments under the system were those with high rates of GME, blended M+C payment rates, and many M+C enrollees. Because there was not complete overlap between these two sets of counties, there were counties that had hospitals that gained GME payments but did not have plans that lost M+C payments.

In other words, they had their cake and ate it too. Examples of these areas include Philadelphia, Pittsburgh, Manhattan, and Houston.

DR. ROWE: I'm a little confused by the use of the

word counties because this slide says the impact of the carve-out on teaching hospitals, but you're talking about counties. Before you were talking about counties and you meant the plans.

MR. WINTER: Right.

DR. ROWE: When you say counties here now you mean the teaching hospitals?

MR. WINTER: What I'm looking at is, at the county level what were counties that had teaching hospitals that received medical education payments under the system, and also within the same county what was the impact on M+C plans payments in those counties.

DR. ROWE: I'm just suggesting in the text or whatever that we talk about teaching hospitals in counties, or health plans in counties.

DR. NEWHOUSE: Place of service versus place of residence.

DR. ROWE: Right.

MR. WINTER: I'll do that. Thank you.

Given this background on the M+C payment system and the carve-out, the Commission may wish to consider how to treat medical education payments in the context of its

recommendation that payments to M+C plans and fee-for-service spending be financial neutral in local areas.

On the one hand, in its previous reports the Commission has treated medical education payments as payments for enhanced patient care received in teaching hospitals. Thus, when we determine M+C payments GME should be treated the same as other fee-for-service spending on patient care. Therefore, it should be included in the payment rate.

On the other hand, the carve-out helps ensure that M+C enrollees have access to teaching hospitals by providing hospitals the same GME payment for M+C and fee-for-service beneficiaries. If we start to include GME in the M+C payment rates, plans would be able to use the GME for other purposes and enrollees' access to teaching hospitals could be limited.

That's my presentation and I look forward to your comments and feedback.

DR. ROSS: I just wanted to add one reiteration to what Ariel said on that to make sure it didn't get lost in the bullets because it relates to that second point, that on the other hand, which is the premise behind the carve-out

was to bypass some of the negotiations that might go on. But the practical impact under the current payment system has moved money from one county to another. That was news to me and I found that interesting.

DR. NEWHOUSE: I don't know about that. If I'm a patient in Arlington and I come in and use Georgetown Hospital -- that's not what you're talking about?

DR. ROSS: No, that's not what it is. The money is moving around because of the blend issue. I don't believe, and you guys could correct me on this -- it's not a question of somebody living in Arlington and going to Georgetown. It's a question of a carve-out happening in one county and that money showing up across the country. It's a complete anomaly in the payment system.

DR. NEWHOUSE: Why is it showing up across the country? It's just not showing up in certain counties because the blends and the floors are binding there and take precedence over the carve-out. So I don't --

MS. BURKE: Isn't it showing up in teaching hospitals?

DR. ROSS: But not necessarily -- the money that is removed from the payments to M+C plans in one county is

not necessarily showing up as higher payments to teaching hospitals in that county. It is showing up as higher payments to teaching hospitals in some other county.

DR. NEWHOUSE: Because those counties are in floor and blend --

DR. ROWE: The idea was to make sure that whatever county your mother lives in, who's a Medicare beneficiary, that she would have access to the academic medical centers or to the teaching hospitals that she would go to. I thought that was the idea, right? And what you're saying is that's not --

MR. MULLER: The floor factor -- I'm lost now. Is this more the floor effect, or is it more the effect of where they go compared to where they live?

MR. WINTER: The biggest impact is the anomaly in the payment rate. That is doesn't come out of the floor or the minimum update counties. The factor of people who live in Arlington going to Georgetown Hospital and therefore Georgetown Hospital getting the additional medical education payment might be a small part of that. But the much larger impact is as a result of the way the payment system is set up.

DR. NEWHOUSE: Let me try to frame because I've got to walk out of here momentarily. I think it goes along the lines Jack started but it's which type of error you would rather live with. I look at this as, this is put in as a payment to the teaching hospitals saying, if you want access to this money you're going to have to admit Medicare beneficiaries. Only from M+C, the only way you're going to be able to do that is offer the plan a competitive rate. Your rates are higher. Here's some money that you can use to subsidize your rate and compete with non-teaching hospitals for M+C business.

MS. BURKE: Joe, having been involved in this substantively at the outset, as you were, the intention as I recall was to essentially pull out of a rate that was going to be paid to an institution a teaching cost that that particular institution was not going to incur because they didn't do teaching. That in calculating the rates we wanted to separate out if you essentially were providing benefits to a Medicare beneficiary in a teaching facility, that teaching facility should receive the money that is targeted to teaching costs.

DR. NEWHOUSE: This goes back to the notion that

the higher rates are really not teaching costs from the old GME report. But let me deal with the two types of errors you have. The issue is whether you -- to what degree the plans -- let's assume for the sake of argument that there's some people in teaching hospitals that could be equally well treated in non-teaching hospitals at the moment. So there's some efficiency gains from reallocating patients toward non-teaching hospitals that plans let's assume would do even if --

MR. MULLER: Contrary to patient choice --

DR. NEWHOUSE: If they got the money, that that's what they would do. On the other hand, they might also take some people out of teaching hospitals that should be in teaching hospitals by some criterion because of the financial incentive to do that if they got the money.

So as I read this carving the money out, it's basically to take both incentives away from the plans; the incentives to move out appropriately and move out inappropriately. So that the judgment about whether it should be carved out really turns on to what degree one thinks plans would take people out appropriately versus take people out inappropriately.

DR. ROWE: What's your opinion about the effect of your epiphany on this?

DR. NEWHOUSE: I don't think it's -- what I just said, both ways it's consistent with that. That is to say I think this is --

[Laughter.]

DR. NEWHOUSE: If you say what we're buying is we're buying a different product when you have this patient at a teaching hospital, it's a different and more costly product, and it is on balance worth it, but for some patients it's not worth it. Then the issue becomes how sensitive the plan is if it gets the money rather than the teaching hospital, in removing the people that one would say by some criterion should be removed, versus removing the people that one would say shouldn't be removed.

DR. ROWE: Is your opinion influenced by the point that Murray made about the way it was actually working out?

DR. NEWHOUSE: That really is another point. I accept Murray's point, but that seems to me to argue for, if you want to pull it out of the blended counties, you should pull it out of everything and not just the floor and the blend.

MS. NEWPORT: I'm troubled by that. This is a solution that was based on the old AAPCC payment method which it was imposed simultaneous with the new payments, and we have to understand that. So the value may -- if the payment methodology had stayed the same, may have been a value. Now it's anachronistic in terms of what it does, and in effect with the 2 percent updates for most of the counties because the blend or everything else is eaten up -- eats up any rate increases, this is a zero sum game.

MR. MULLER: But the 2 percent cap would have the problems you say it has independent of this carve-out.

MS. NEWPORT: Yes. But the findings here, which may have been surprising to some people, aren't really that surprising when you look at the congruence of events and what the timing was, in terms of what it was designed to do.

MR. HACKBARTH: We've got to get this to a conclusion. On this particular topic, is there anything else that you need from us today? If not, I'll let Ray have the last word on this and then we need to go on.

DR. HARRISON: I think there are two problems. One is the short-term problem where we have money coming out of different counties and where it's going back in. And

then the long-term problem is how do you rationalize this with the epiphany?

MR. HACKBARTH: We're not going to resolve those today, I dare say.

DR. STOWERS: My quick comment is two things. One, I don't think the county has anything to do with the service area, which we've said is not a major part.

My second part is this is dollars that would have been in Medicare that are now going to the Medicare+Choice plans and nowhere in fee-for-service do we try to connect where the GME dollars are coming from to where they're going, because the entire nation -- and all of Medicare pays for GME wherever it occurs. And now we're starting to try to take a local area and apply to where the GME is going.

I think we're making a quantum leap there at all to even think that the GME dollars out of a particular area that has managed care should only go to GME in that area. Because nowhere else in Medicare do we do that. The entire nation pays for GME.

So to try and link that back to one particular county --

MS. BURKE: But in the fee-for-service model it

pays for --

DR. STOWERS: But as many as would have been in -- if the money, as a pool, was all paying for GME across the nation, that part was not taken out when the money was handed to Medicare+Choice.

MS. BURKE: But in fee-for-service it tracks where the person is. The multiple is applied to where the patient is as an inpatient. It's not generic. If I'm in a non-teaching hospital, I don't get an adjustment.

MS. NEWPORT: But it doesn't go to the plans.

DR. STOWERS: But in the 95 percent was the GME dollars. That's why they're taking it back. But we're trying to take it back to a specific region of the country, not taking back and putting it in the whole pool.

MR. HACKBARTH: We need to move on because we're not going to resolve this issue today.

We've got one last piece. I appreciate people's patience. It is important, though, that we at least have a preliminary look at the competitive issue. Scott?

DR. HARRISON: Another issue you won't resolve today, I'm sure.

MR. HACKBARTH: I think that's important to keep

in mind, Scott. What I think we're trying to accomplish here is get the issue on the table and introduce it. Please handle your presentation accordingly.

DR. HARRISON: Let's take a look at what we might mean by the term competitive bidding, just quickly. A common conception of competitive bidding is that of a winner-take-all auction where the lowest bid wins and gets the contract. Often under these types of arrangements quality or other factors like product differentiation only make a difference if the bidding mechanism makes a provision for them.

But I want to get away from this definition because it really wouldn't do anything -- this conception doesn't do anything to add choice for beneficiaries and this really is not the premise behind any Medicare+Choice or Medicare reform proposals.

Instead, I want to focus on the conception of competitive bidding that is embodied in the concept of the free market for health insurance. Insurers would develop products with quality and other characteristics that they would include as part of their offerings or bids. Buyers, in this case beneficiaries, would face marginal price

decisions for the different offerings and would make price/quality/convenience tradeoffs.

This competitive bidding concept could accommodate either using the bidding results to set the government contribution or not.

We already have this form of competitive bidding in the Medicare+Choice program. Plans compete against one another on the basis of benefits and premiums. They even compete against the Medicare fee-for-service program, although there are limits to the parameters of competition.

One of these limits will be loosened in 2003 when a BIPA provision kicks in that will allow plans to rebate all or a portion of the Part B premium to their enrollees. Currently, Medicare+Choice organizations cannot offer plans that are less expensive than the fee-for-service program, only plans with richer benefits. So this change in 2003 may change the competitive dynamics and allow freer competition with the fee-for-service program.

Even with freer competition, most beneficiaries will remain unaffected. The beneficiaries in the traditional Medicare fee-for-service program receive the same benefits at the same price, regardless of whether there

are competing plans in their areas, and there are no competing plans in many areas.

Finally, an important point for this topic is that the competition does not affect the government contribution, otherwise known here as the Medicare+Choice payment rate.

Given that we have a level of competition, and in light of our recommendations for financial neutrality between enrollment in Medicare+Choice plans and enrollment in the traditional fee-for-service program, what could we hope to gain from having the results of competitive bidding being used to set the Medicare+Choice payment rates? Proponents suggest that competitive bidding would encourage greater competition, reduce Medicare costs and be more equitable across the country.

Would payment rates based on competitive bidding encourage more plan entry? In areas where there are not currently any plans, it's hard to come up with any reasons why a plan that was not already participating would decide to participate under competitive bidding rules that could only lower payment rates compared with the financial neutrality model.

Participation could even be discouraged if

competitive bidding did not include a traditional Medicare fee-for-service program. Under such a model, the plans would only be competing with themselves and low bids would result in lower payment rates and would leave the fee-for-service program unaffected. I think we saw some fears of this in the demonstrations. Because plans would be at a disadvantage relative to fee-for-service, they would be less willing to participate than under a financial neutrality framework.

One type of competitive bidding model should not hurt plan participation relative to a straight financial neutrality model and participation might perhaps increase due to a possible change in the competitive dynamics.

If the traditional program local area costs were treated as a bid, the relative bids of the plans would look the same as under financial neutrality and thus, participation would be likely to stay the same barring new dynamics.

As far as saving money, any time bids come in below the Medicare fee-for-service costs, there is the potential to lower total Medicare costs through higher premiums paid by beneficiaries.

One model would change the effects from geographic variation in fee-for-service spending. The model would result in beneficiaries in different areas paying different premiums for the traditional program instead of the current situation where different beneficiaries in different areas have access to different benefit packages at the same price.

Let's take a look at this type of model as an illustration. This model would have plans bid on a set of standard benefits. The local Medicare fee-for-service costs would be considered as the bid for the traditional Medicare plan. The payment rates would be set based on the bids. The general idea is that the rate would be set at the lowest bid and you might need to make some adjustments so that you could guarantee everybody a plan if they wanted one at the lowest bid.

Because everyone could always get into traditional Medicare, the payment rate would never be above the fee-for-service rate. In areas where there were no plans, the payment rate would always equal the fee-for-service rate. Beneficiaries would then pay additional premiums to join plans, including the fee-for-service plan, that had bids above their local payment rate. The additional premiums

raised could be used either to increase the level of benefits in the nationwide standard benefit package, or could lower the overall cost of the Medicare program to taxpayers.

What might be expected to happen under this type of system? First, the nature of the Medicare entitlement would change. Beneficiaries would no longer be entitled to receive the traditional Medicare fee-for-service program for a set premium. Instead, beneficiaries would be entitled to receive the same benefit package that is offered under the traditional Medicare program but would not be guaranteed that those benefits would be delivered through the broad choice of providers that are available in the fee-for-service program.

The gains from lower bids generated by competition would shift from the enrollees in the less costly plans -- that's currently who receives the benefits -- to all beneficiaries and/or taxpayers. All beneficiaries nationwide would have access to the basic benefit package at the same premium, but all would have to pay more if they wanted a more costly plan, unlike the current situation where beneficiaries in some areas have access to plans with

extra benefits for no additional premiums.

Cost growth under this type of system would depend on the results of the annual bidding process, but total spending in any local area would be limited to the level of per capita fee-for-service spending in the traditional Medicare fee-for-service program.

That ends the presentation and I'd like to know what parts of this you'd like to see incorporated in further work, as well as any of the other topics.

MR. HACKBARTH: If I understand this correctly, this has major dramatic implications. It basically says the one competitive bidding model that makes sense from a conceptual standpoint, you basically have to abandon the entitlement to a free choice fee-for-service plan. The entitlement is no longer that. The entitlement becomes payment for the low cost bidder, which may not be a fee-for-service plan at all but a restricted choice plan. So that's a huge philosophical shift.

If you're not prepared to do that, the other models of competitive bidding don't seem to make a whole lot of sense to me, or difference. In fact, they could make things worse in terms of participation, but they're unlikely

to make things better.

DR. HARRISON: I agree.

DR. REISCHAUER: What are you saying, that if you aren't willing to sign on to something like this, it's not worth pursuing? I mean, because this is really the most radical of the alternatives that are out there, and none of the legislation that's ever been proposed goes this far. The furthest would be the Bipartisan Commission where you had a weighted average reference premium, as opposed to the lowest premium.

DR. HARRISON: You could incorporate something like that, but you'd have similar results, probably.

MR. HACKBARTH: But the basic point is that you'd have to change the notion of the entitlement. It's no longer to an open choice fee-for-service plan, but rather to a bid. And that could be an average of bids, it could be the lowest bids, but it wouldn't necessarily -- or perhaps even likely -- be a free choice plan.

And so you would be paying more for --

DR. REISCHAUER: There's a question between the entitlement and what you have to pay for it and whether everybody in the nation has the right to pay the same

amount. Those are sort of different variants. But there still would be an entitlement at some price to a fee-for-service Medicare benefit package.

MR. HACKBARTH: At some price.

DR. REISCHAUER: The question is, depending on where you set the reference premium, are you -- you can set it, as the President did and Breaux-Frist II does, at the fee-for-service cost in every area.

DR. HARRISON: Which is basically the financial neutrality principle.

DR. REISCHAUER: Yes, the financial neutrality principle or somewhere else.

MS. NEWPORT: I guess in our direction to you, we asked you to look at some of this stuff. I guess following on that discussion is where do we go from here, in terms of the chapter? In my mind, I think I was really thinking about are we going to set some bounds on what this could look like? What the positive/negative impacts of that might be? I guess I'm trying to figure out how we give him meaningful direction on what we really need to look at.

I think this actually was good and it helped get me to think about this a little more dynamically. But I'm

not sure that we have time enough to give you the right kind of ideas on this.

Glenn, did you have a concept?

MR. HACKBARTH: I actually think what Scott presented is very helpful. The big problem right now is that we've got too little time and too few commissioners to discuss it. So rather than having Scott go off into a lot that's new, I'll defer to Bob and he'll tell Scott to go off and do a lot that's new.

DR. REISCHAUER: It strikes me that if we were going to describe illustrative models, we really should describe three at a minimum. This, one that's based with a reference premium to some average. And so in some areas fee-for-service could cost and in some areas it wouldn't. And the one which is, to the extent anything is in political play, is in play now, which is the reference premium being fee-for-service Medicare. And then the consequences of each of those for cost savings, for enrollment, for whatever.

DR. ROSS: One of the things that would be helpful to staff -- and I recognize we need a broader participation to get this, what do we want to get out of all of these mechanisms? Part of what we wanted to bring you was the

Commission has moved to this financial neutrality principle, yet everybody talks about competitive bidding. Our reaction is well, if by competitive bidding you mean plans set their own premiums, effectively we'll have that in 2003.

Then what is it we want from competitive bidding? Is it savings? Is it something else? We can bring you a couple of options and work through that.

MS. NEWPORT: You'll say that we'll have that in 2003. You're presuming we will have legislation next year to do that?

DR. HARRISON: There is a provision -- it may not be free. You will be able to come in, this year it will be $54 below the fee-for-service plan. You could rebate up to the full Part B premium next year, which you couldn't do now.

DR. REISCHAUER: With all that spare cash you have, Janet.

MS. NEWPORT: Frankly, you know, $1.40 isn't going to cut it. I'm being facetious.

I guess I'm having trouble thinking that that is a real live -- it's not on our radar screen as something that's an important competitive bidding factor.

MR. HACKBARTH: I like Bob's suggestion. We probably need to spend a little time reviewing some of the presentation from today, since a lot of people missed it, supplement it with the different models and the implications for savings and what not.

DR. HARRISON: There actually is a Health Affairs article out now. It might be only a web version. But it's by Ken Thorpe and Adam Atherly, I believe. It actually looks at three models and gives national figures for savings in enrollment. We could differ on some of the assumptions of enrollment, but I think I can cite a lot of that work.

MR. HACKBARTH: All right. We're finished with this.

Public comment? The microphone is open.

MS. SCHALLER: I'm Candy Schaller. I'm the vice president for regulatory affairs with the American Association of Health Plans. I'd like to speak briefly to the risk adjustment issue.

Obviously, many of our plans participate in the Medicare+Choice program so we've been very deeply interested in seeing a risk adjustment mechanism that is far more workable than the one that plans have currently experienced.

We've identified, as you have, the same sorts of problems. One with the data stream, which I think we see in two parts. One, a great complexity with respect to the data elements that have been required, but secondly also an exceedingly high volume of data that would be required as plans move from an environment where they are submitting inpatient only data to the much broader environment of ambulatory data.

And secondly, of course, the PIP DCGs and the limitations that you all have discussed there are also very real to us. One important aspect of that is that the PIPs do not compensate plans appropriately for situations in which, in fact, they are successfully treating patients on an outpatient basis that might otherwise be hospitalized. So that's certainly one of our interests in moving beyond the inpatient only data scheme.

I think, from our perspective, the productive direction in which to look has also been alluded to in some of the discussion that you had today. One, with respect to reducing the number of data elements very significantly. But we also think it's important to look at establishing a requirement for a data stream that is realistic for the

plans to achieve.

Based on our dialogue with our plans and experience over the last few years, we don't think it's realistic to believe that plans can establish a robust enough data stream from a broad spectrum of ambulatory sites of care and every provider in order to be able to be paid fairly under a risk adjustment mechanism that requires that kind of effort.

Therefore, we've been looking at maintaining the current inpatient data stream and adding to it some ambulatory data, perhaps focused on diagnoses that would be selected based on their high prevalence or high cost and/or plans' likelihood of keeping people out of the hospital who might otherwise be hospitalized. So focusing on some of those high interest, high concern areas.

Also, I think we believe that moving to a somewhat more complex risk adjustment system, perhaps looking at something like the HCCs, may offer some improvement in the accuracy of the payment mechanism. And sort of combining all these things together may result in a picture that provides a better balance between the need to improve data accuracy, which we support, but also the very important

aspect of keeping the burden on both plans and providers to a manageable level so that we can have a robust program overall.

Thanks.

MR. HACKBARTH: Seeing no other commenters, we are adjourned until December. Thank you very much.

[Whereupon, at 12:23 p.m., the meeting was adjourned.]